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# Montana

# Public Mental Health System

## Revised State Plan

## Fiscal Years 1992 - 1994

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# I. INTRODUCTION

The Department of Corrections and Human Services is the designated mental health authority for the State of Montana. Unless otherwise indicated, the Department of Corrections and Human Services will be referred to in this Plan as the "Department." The state legal mandate for the development and implementation of this Plan is provided in Title 53, Chapter 21, Part 2, Montana Code Annotated (MCA). PL 99-660 establishes federal requirements for state comprehensive mental health plans.

## I.1 Purpose of Plan

The Montana Mental Health Plan will guide and coordinate the development and implementation of mental health services in Montana consistent with state statute and the requirements of PL 99-660. The Plan provides a basis for the effective and efficient allocation and utilization of current federal and state funds available for mental health services. It is responsive to changing needs, services, and resources. Its development was based on input from Montanans representing diverse interests and points of view. The focus of the Plan is on priority populations consistent with state and federal priorities.

## I.2 Mission Statement

The Department's mission for mental health services is to develop a comprehensive public mental health system which: 1) provides treatment, rehabilitation, and support services for psychiatrically disabled adults; 2) provides treatment and support services for emotionally disturbed children/adolescents and their families; and 3) assures the availability of basic mental health services to those who would otherwise be unable to pay.

## II. MONTANA PUBLIC MENTAL HEALTH SYSTEM

The Department of Corrections and Human Services is designated by state law (53-1-201, MCA) as the state agency to ". . . develop and maintain comprehensive services and programs in . . . mental health".

Specific duties of the Department as they relate to community mental health services are described in Section 53-21-202, MCA:

> "The department shall:
>
> (1) take cognizance of matters affecting the mental health of the citizens of the state;
>
> (2) initiate mental health care and treatment, prevention, and research as can best be accomplished by community-centered services. Such means shall be utilized to initiate and operate these services in cooperation with local agencies as established under this part;
>
> (3) collect and disseminate information relating to mental health;
>
> (4) prepare and maintain a comprehensive plan for the development of public mental health services in the state;
>
> (5) receive from agencies of the United States and other state agencies, persons or groups of persons, associations, firms, or corporations grants of money, receipts from fees, gifts, supplies, materials, and contributions for the development of mental health services within the state;
>
> (6) establish standards for mental health programs that receive funds from the department; and
>
> (7) evaluate performance of programs that receive funds from the department in compliance with federal and state standards."

Within the Department, the Mental Health Division is the organizational entity with responsibility for the mental health system. The Mental Health Division consists of three components: operations, residential services and community services.

### II.1 Operations Component

The Operations Component consists of the state level administrative staff as well as the Mental Health Planning and Advisory Council.

The state staff consists of four full-time professional positions plus 2.5 FTE currently funded by federal grants. This staff has overall responsibility to plan, evaluate, manage and coordinate the mental health system.

The Division develops contracts with community-based providers on an annual basis, using a process of seeking broad input into determination of contract language and allocation of funding. A major staff activity is the monitoring of contracts to assure compliance with program standards.

The Mental Health Division annually conducts on-site reviews of the community mental health centers to evaluate treatment programs, clinical records, staff qualifications, and data collection systems. The purpose of the evaluation procedure is to ensure that the centers are complying with state and federal standards and contract requirements.

State and federal law require the Department, with advice and recommendations from the State Mental Health Planning and Advisory Council, to prepare and maintain a comprehensive plan for mental health services for the State of Montana. Planning is an ongoing activity. Service and fiscal data are collected and reviewed at least quarterly. Consumer and family input is systematically collected during major planning cycles and informally obtained on an ongoing basis via the Planning and Advisory Council, consumer participation on various boards and committees, informal contact with consumer and family organizations and with individuals. Progress on plan initiatives is monitored on an ongoing basis and formally reviewed every six months.

The planning process calls for the State Mental Health Plan to span a three year period with a formal revision or new plan to be completed by September of each odd numbered year. To clarify:

| Plan Development Date | Years Covered by Plan |
|---|---|
| September, 1991 | FY 1992-1994 |
| September, 1993 | FY 1994-1996 |
| September, 1995 | FY 1996-1998 |

Under this schedule the Plan is completed following the completion of the biennial legislative session, allowing access to up-to-date information on legislative action including resources available and new legislation impacting mental health services. The third year covered by each plan will serve as a "transition" or carry over year by becoming the first year in the new or revised Plan.

Fiscal, consumer and service data which document the purchase of mental health services in the community are collected by the Mental Health Division and are reviewed and evaluated at least quarterly. With the assistance of service providers, a major effort will be continued to develop and enhance data gathering systems for the development of better information for planning and contract monitoring.

The Division has completed its Human Resource Development (HRD) Capacity Building project and is currently in the second year of an HRD Special Demonstration Project. Both projects have been funded by grants from the National Institute of Mental Health (NIMH).

Under the capacity building project the Division was able to perform a system-wide needs assessment and develop a list of priority HRD concerns. These issues and strategies for addressing them became the core of the state's HRD Plan, which was used in the development of this Plan. Additionally, the capacity building project resulted in a number of concrete activities to meet identified HRD issues. These included establishment of a mechanism to provide continuing training to mental health workers, a cooperative recruiting effort among institutions and CMHC's to locate candidates for hard-to-fill positions, the initiation of productive linkages with Montana's universities, and a comprehensive survey of the mental health workforce.

The special demonstration project has four distinct goals, all of which rely upon collaborations between the publicly-funded mental health system and the state's institutions of higher education to solve a number of the state's priority HRD concerns. These goals include the development of model curricula at the baccalaureate and master's levels for training Montanans to be effective mental health service providers, increasing the use of public-sector mental health agencies for student field experiences, developing personnel exchanges between provider agencies and higher education institutions, and establishment of a pilot program that

will allow place-bound rural Montanans, mental health consumers, and under-educated mental health workers to obtain training to become service providers in their home communities. Each of these is reflected within the goals of the present plan.

The Department serves as the agent of the State executive branch in communicating with federal agencies and administering federal mental health funds including the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant. Federal funds are allocated by the Department based on state and federal priorities. The Mental Health Division is the communication liaison and coordinates between the federal government and the mental health service system regarding issues affecting mental health services. The Division continually pursues federal funding opportunities and assists local agencies in applying for federal funds.

## II.2 Residential Services Component

The residential services component of the Mental Health Division consists of two state institutions: Montana State Hospital and the Montana Center for the Aged.

Montana State Hospital (MSH) consists of campuses at Warm Springs and Galen, approximately four miles apart. The Warm Springs campus is designated as the adult state mental health facility and provides inpatient psychiatric treatment for those mentally ill adult Montanans who cannot effectively be served in existing community based alternatives. The Warm Springs facility had an average daily population of 286 in FY 1991.

With regard to MSH, major emphasis in this Plan is to: a) redefine the hospital's mission; b) reduce inappropriate admissions; and c) improve the process of transition for patients going from hospital to community.

The Galen campus provides residential treatment for persons suffering from chemical dependency, acute hospital care for patients from both Montana State Hospital campuses, and intermediate nursing care for individuals who require nursing services.

The Montana Center for the Aged is located in central Montana at Lewistown. It is a licensed facility for the long term care and treatment of persons 55 years of age or older who have chronic mental disorders and who require a level of care not available in the community, but who cannot benefit from intensive psychiatric treatment. The Center had an average daily population of 143 in FY 1991.

## II.3 Community Services Component

Montana community mental health services are provided by a variety of local agencies as well as independent private practitioners and short term psychiatric inpatient units. Virtually all of the Department's community mental health funds are used to purchase services from five regional mental health centers. These centers are established by state law (Title 53, Chapter 21, Part 2, MCA) as private nonprofit organizations. Each center serves a multi-county region and each participating county commission appoints one person to the Center's governing board. As a result of 1991 legislation each governing board is now required to include a primary consumer, a family member of a consumer, and either a parent of a child with an emotional disturbance, a person representing the interests of the elderly or a health care professional.

State law (53-21-201, MCA) provides the following formal definition of "community mental health center" for the Montana system.

> (1) "Community mental health center" means a facility, not necessarily encompassed within one building, that is licensed by the department of health and environmental sciences as a mental health center, as defined in 50-5-101, and that offers comprehensive mental health services that include at least the following services to the public:
>
> (a) outpatient services, including specialized outpatient services for children, the elderly, individuals who have serious mental illness, and residents of its service area who have been discharged from inpatient treatment at a mental health facility;
>
> (b) 24-hour-a-day emergency care services;
>
> (c) day treatment or other partial hospitalization services or psychosocial rehabilitation services;

(d) screening for patients being considered for admission to state mental health facilities to determine the appropriateness of admission; and

(e) consultation and education in mental health.

## II.4 Financial and Staffing Resources

The financial and staffing resources which are available to the mental health system for fiscal years 1992 and 1993 are summarized below. These are the resources currently available to carry out the activities proposed in Section VI of this Plan.

| | Funding | Staffing |
|---|---|---|
| FY 1992 | $33,138,862 | 784.78 FTE |
| FY 1993 | $34,254,633 | 784.53 FTE |

For fiscal year 1992, these funds and staff have been allocated to mental health system components as follows:

| | Funding | Staffing |
|---|---|---|
| Montana State Hospital | $23,050,492 | 671.61 FTE |
| Montana Center for the Aged | $ 3,407,114 | 108.17 FTE |
| Community Mental Health Programs | $ 6,302,714 | N/A |
| State-Level Administration | $ 378,542 | 5.0 FTE |

Community mental health funding for FY 1992 is allocated according to the following contracts:

| | Fee-for Service Contract | Intensive C.M. Contract | Sp.Ed. -MH Joint Serv. | Pilot Comm. Projects | Total |
|---|---|---|---|---|---|
| Region 1 CMHC | 656,607 | 63,320 | 14,237 | | 734,164 |
| Region 2 CMHC | 1,127,669 | 180,125 | 27,700 | | 1,335,494 |
| Region 3 CMHC | 905,360 | 144,384 | 32,500 | | 1,082,244 |
| Region 4 CMHC | 837,682 | 177,662 | 44,891 | 311,440 | 1,371,675 |
| Region 5 CMHC | 1,043,639 | 243,351 | 30,000 | 376,359 | 1,693,349 |
| Friends to Youth | 41,800 | | | | 41,800 |
| Total | 4,612,757** | 808,842 | 149,328 | 687,799 | 6,258,726* |

* $43,988 is unallocated as of October 1, 1991.

** No less than $3,831,439 of the Fee-For-Service Contract are earmarked to fund services for children/adolescents and adults with severe and disabling mental illness.

Funding allocations for FY 1993 have not been made.

As the Department identifies needed program changes consistent with this Plan which may require more financial and staff resources, these additional needs will be documented as part of the process of developing an executive budget recommendation for the 1993 legislature. The Department will advocate and document the need for the executive budget request.

The data presented here represent only those funds and staff which are the responsibility of the Department. Substantial additional financial support for public mental health services is provided by Medicaid and other entitlement programs, client fees, private insurance, county contributions to community mental health programs, and services purchased by agencies such as the Department of Family Services and public schools.

## III. ANALYSIS OF CONSUMER POPULATIONS

This section of the Plan includes a discussion of four populations of consumers:

1. Elderly people with mental health problems.
2. Minorities with mental health problems.
3. Homeless mentally ill.
4. Adults, ages 18-64, with mental health problems. (This group consists primarily of non-elderly adults who do not have disabling mental disorders)

Sections IV and V of this Plan contain more extensive descriptions of the priority populations of children/adolescents with severe emotional disturbance and adults with severe and disabling mental illness.

### III.1 Elderly People with Mental Health Problems

While elderly people with mental illness are in many ways similar to other mentally ill people, there are several features regarding the population that need to be noted:

1. The elderly are the fastest growing segment of our population and they have a higher incidence of mental health problems than the population at large.

2. Nationally and in Montana, the elderly receive a smaller share of mental health services than would be expected based on population statistics alone.

3. Of those over age 60 seeking services from community mental health centers in Montana, "affective disorders" are by far the most common diagnosis (30%), followed by "other non-psychotic disorders" (19%), "schizophrenia and related disorders" (14%), and "organic disorders not alcohol or drug related" (12%).

4. As a group the elderly frequently must deal with severe disrupting losses (spouse, productivity, income, independence, home, family supports, etc.), many of which are permanent in nature. Such losses frequently cause severe stress which can lead to depression.

5. It is often noted that the elderly are particularly reluctant to seek out help, especially in the area of mental health.

6. Nationally, the elderly (60 years and older) constitute approximately 12% of the population. In 1982, they comprised only 6% of the total CMHC caseload nationally, despite estimates that the elderly have a higher incidence of significant mental health problems than the general population.

For purposes of this Plan, "elderly people with mental health problems" include all people 65 and older who have significant mental health problems. Given the high frequency of mental health problems among elderly people and the relatively low frequency of service, it is clear that the elderly have many unmet service needs.

## III.2 Minorities with Mental Health Problems

Subgroups included in our consideration of "minorities with mental health problems" include cultural and ethnic minorities and those with unique problems caused by physical disabilities, such as deafness.

Ethnic and racial minority populations in Montana are relatively small. Native Americans are by far the largest group comprising approximately 4.6% of the state's population (2.9% on reservations and 1.7% off reservations). Other minority groups and their percentages of the state population are: Hispanics, 1.2%; Asians, 0.4%; and African Americans, 0.2%. Little quantified information is available on minority mental health problems in Montana and, because of low populations, the percentages of mental health services going to minorities is minimal. Comparison figures showing percent of state population (first figure) and percent of CMHC admissions (second figure) are as follows: Native Americans, 4.6% to 6.1%; Hispanics, 1.2% to 1.0%; Asians, 0.4% to 0.1%; and African Americans, 0.2% to 0.6%.

While the small populations minimize the actual demand for mental health services, the alienation, depression, and anger related to prejudice, discrimination, and poverty may place ethnic minorities at a high risk for mental health problems. These and other problems underscore the need for culturally appropriate and accessible community mental health services.

A Community Mental Health Needs Survey completed in 1988 identified the following two items as top priorities for service development relative to minorities: require staff training regarding culturally sensitive mental health services for minorities; and fund special outreach activities to identify minorities with severe mental disabilities.

While it is probably not feasible to develop programs or services that are specifically geared to the special or unique characteristics of all ethnic, racial, or other minorities, it may be possible to identify concentrations of populations within small geographic regions. Such identification would allow more effective outreach and identification of those with mental health problems, and more effective training to enhance cultural awareness and sensitivity among mental health staff.

### III.3 Homeless Mentally Ill

For purposes of this Plan the term "homeless" includes those who are homeless or at imminent risk of becoming homeless defined as follows:

A homeless person is:

1. An individual who lacks a fixed, regular, and adequate nighttime residence, or

2. An individual who has a primary nighttime residence that is:

    a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

b) an institution that provides a temporary residence for individuals intended to be institutionalized; or

c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

A person is considered to be at imminent risk of becoming homeless in he/she has one or more of the following characteristics:

1. Most recent two residences were occupied for less than one month each (present and last residence);

2. Residential history that indicates two or more instances of homelessness in last year (excluding psychiatric hospitalizations and transitional or group home housing for the mentally ill) combined with less than six months in present residence;

3. Recently left psychiatric hospital, group home, or transitional living facility, presently living independently, and two or more "risk factors" are present;

4. History of transient lifestyle (lived at present and prior residence six months or less, a history of changing residences frequently, and interpersonal difficulties and/or behavior patterns that have led to evictions in the past) and three or more "risk factors" are present; or

5. An individual who has had a major disruption in his/her life (divorce, thrown out of parents' home, etc.) or is facing a major disruption with little or no planning for the change and has three or more "risk factors" present.

The "risk factors" referred to in the above definition are:

a. Isolated with inadequate social support network

- not married
- few friends
- infrequent or no contact with relatives
- little or no contact with community groups

b. History of multiple psychiatric hospitalizations
c. Alcohol and/or drug problems
d. Poor independent living skills
e. Money management deficits
f. Poor economic supports
g. Minimal vocational skills
h. Borderline intellectual functioning
i. Refusal of medical/mental health care
j. Only means of financial support is family

People who are homeless and mentally ill are a multi-need group experiencing poverty, personal and family problems, and substance abuse, as well as possessing minimal social skills. Though the number of Montanans who are homeless appears to be small when compared to the more visible problem in urban areas, problems exist in successfully and effectively providing services to this population.

### III.4 Adults, Ages 18-64, with Mental Health Problems

This is a diverse group of individuals with a variety of mental health needs. Although most might be functioning well socially and vocationally with some need of short term therapy, others may be experiencing emotional instability at a level where their ability to function in the workplace or social realm is marginal.

The therapeutic services used most often by this group are individual and group outpatient therapy and emergency services. The timely availability of these services for those individuals experiencing a crisis requiring intervention is an important component of the mental health system. Currently in some areas of the state people in need of outpatient services, other than emergency, are placed on a waiting list for four to six weeks before they can be served.

Emergency services by telephone, or face-to-face if needed, must be available 24 hours a day to those in crisis, especially for those who may be a danger to themselves or others.

Therapy services, either individual or group, may be needed for those individuals who are experiencing a personal trauma in their lives which has affected their ability to function at work, school, or home and which has the potential of disabling them further. Individuals who have been the victims of violence and those who are experiencing a difficult divorce or bereavement are examples of the type of life crisis that may require short term mental health services. Others may be experiencing an episode of serious mental illness for the first time and need help in dealing with the symptoms, as well as identifying available treatment and services. The availability of these services in the public mental health system may be particularly important in the rural and remote areas of the state as these are areas in which private mental health providers are not likely to be found.

In addition to adults experiencing a need for emergency services and short term crisis intervention as described above, there are other adults in this population group who may require mental health services. Therapy programs for those with problems which may make them a danger to society, such as sexual offenders, are needed mental health services in the community.

Psychological evaluations of adult clients for other social service agencies is another service that is needed for this population group. Vocational Rehabilitation, the Department of Family Services and other agencies routinely request evaluations to determine the extent of impairment of individuals seeking services from these agencies.

## IV. SERVICE SYSTEM FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE AND THEIR FAMILIES

The following discussion presents the system of culturally sensitive mental health services the Department considers integral to the completion of its mission. It is an "ideal" system toward which the state should move. The system provides treatment and support services to children and adolescents with severe emotional disturbance and to their families. The system of services incorporates multiple values including maximum coordination among its many and varied components for the planning, implementing, and financing of its multiple services. The full system will be achieved through a partnership between the state and local governments, public and private providers, business, schools, funding resources, parents, and parent and child advocates. The design of the system acknowledges that preventive or early identification and intervention services are essential and valuable system components directed toward addressing needs before the illness develops into a severe disability. These early intervention services need to be identified, funded, implemented, and coordinated at the local community level as a part of the local continuum of services with the state providing appropriate supplemental support.

### IV.1 Values

The core values for the system of mental health services to children, adolescents, and their families consist of the following:

1. The system of care should be child-centered, with the needs and rights of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility at the community level.

3. The system of services should be designed, developed and implemented with the rights of the child to a safe environment and the preservation of his/her family dictating the nature, character, and intensity of the services received.

4. A child who is emotionally disturbed is a child suffering from an illness that is treatable and the child is entitled to receive treatment from qualified and trained providers.

## IV.2 Principles

The values provide a basis for the structure of a mental health system of services. In addition to these values, underlying principles directing the creation and application of the system are also essential. The following principles flow from the Department's mission and the values stated above:

1. Children with severe emotional disturbance require a range of medical and mental health services which are appropriate and of varying levels of intensity.

2. Children with emotional disturbance almost universally manifest problems in many spheres including home, school, and community requiring intervention of other agencies and systems including special education, child welfare, health, vocational training, and juvenile justice.

3. Needs of children and adolescents with severe emotional disturbance cannot be met by the mental health system in isolation.

4. Children with emotional disturbance should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs. This array of services include services for substance abuse.

5. Children with emotional disturbance should receive individualized services in accordance with the unique needs and potentials of each child, and guided by individualized service plans.

6. Children with emotional disturbance should receive services within the least restrictive, most independent and normative environment that is clinically appropriate.

7. The families and surrogate families of children with emotional disturbance should be full participants in all aspects of planning and delivery of services.

8. Children with emotional disturbance should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.

9. Children with emotional disturbance should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a planned, coordinated, therapeutic, and accountable manner, and that they can move through the system of services in accordance with their changing needs. This principle includes having labels such as emotionally disturbed removed by a team of service providers which includes the child's parent or parent surrogate when services of the mental health system are no longer needed.

10. Early identification and intervention for children with emotional disturbance should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

11. Children with emotional disturbance should be protected, and effective advocacy efforts for children and adolescents with emotional disturbance should be promoted.

12. Children with emotional disturbance should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics.

13. Services should be sensitive and responsive to cultural differences and special needs of the children and their families.

14. Families should receive the supports necessary to maintain their children at home. Family support services must be based upon "whatever it takes"; that is, family supports should be defined broadly and interpreted creatively.

15. Services to children with emotional disturbance and their families should maximize the child's and family's control over the services so as to facilitate their "taking responsibility for healing themselves".

## IV.3 Target Population

Definition of Children and Adolescents With Severe Emotional Disturbance:

A person is a child or adolescent with a severe emotional disturbance when all three Criteria I, II, and III are met:

**CRITERION I.** The person is 17 years of age or younger, **AND**

**CRITERION II.** The person demonstrates a need in addition to mental health services for one or more special care services from two or more human service programs (agencies), **AND**

**CRITERION III.** The youth meets one of the three following conditions:

**Condition 1.** Youth has been identified by an education agency as "emotionally disturbed" according to Section 20-70-401, MCA, **OR**

Condition 2. Youth has a mental disorder diagnosed under DSM-III-R (or revision thereof) by a certified or licensed mental health professional, **AND** the youth consistently and persistently demonstrates one of the following characteristics:

i. the youth has failed to establish or maintain interpersonal relationships relevant to their appropriate developmental stage and their cultural environment; or

ii. the youth displays inappropriate behavior relevant to their developmental stage and their culture; or

iii. the youth fails to demonstrate a range or appropriateness of emotion or mood relevant to their developmental stage and culture; or

iv. the youth displays behavior sufficiently disruptive to lead to isolation in or from school, home, therapeutic or recreation settings; or

v. the youth displays behavior sufficiently intense or severe to be considered seriously detrimental to their growth, development or welfare, or to the safety or welfare of others; **OR**

Condition 3. Youth has no DSM-III-R diagnosis but exhibits severe emotional and/or organic impairment which is manifested by 1) emotional or behavioral symptoms/disturbance, 2) the disturbance has been present for at least six months or is expected to continue for a period over six months, and 3) is consistently and persistently demonstrated by one of the following:

i. the youth has failed to establish or maintain interpersonal relationships relevant to their appropriate developmental stage and their cultural environment; or

ii. the youth displays inappropriate behavior relevant to their developmental stage and their culture; or

iii. the youth fails to demonstrate a range or appropriateness of emotion or mood relevant to their developmental stage and culture; or

iv. the youth displays behavior sufficiently disruptive to lead to isolation in or from school, home, therapeutic or recreation settings; or

v. the youth displays behavior sufficiently intense or severe to be considered seriously detrimental to the youth's growth, development or welfare, or to the safety or welfare of others.

A child or adolescent does not meet the definition of SED when the youth has a primary problem of developmental disability, substance abuse or chemical dependency, victim of sexual or physical abuse, or has a personality disorder characterized by lifelong and deeply ingrained anti-social behavior patterns, including sexual behaviors which are abnormal and prohibited by statute unless the behavior results from emotional disturbance or the youth is dually diagnosed, e.g. developmentally disabled and emotionally disturbed or sexually abused and emotionally disturbed.

State government's primary responsibility is to plan for and implement a comprehensive service system for children and adolescents with severe emotional disturbances. It is clear, however, that many young people who do not meet the criteria stated above have significant problems requiring intervention by a publicly planned service system. That system must, therefore, be available to and

appropriate for children and adolescents who are at risk for severe emotional disturbance.

A child or adolescent can be considered "at-risk" and appropriate for early intervention or prevention services when the child or adolescent has been or is:

| | |
|---|---|
| Physically abused | Sexually abused |
| Involved in alcohol or drug abuse | Neglected |
| Learning disabled | Emotionally maltreated |
| Chronically physically ill or disabled | A child of a chemically dependent parent |
| In foster or group care | Living in poverty |
| Involved with the courts | A status offender |
| Experiencing social disruptions such as divorce, homelessness, death of a family member, etc. | Delinquent |
| | Emotionally handicapped |

Native American youth may be considered at-risk because of the higher potential of exposure to poverty conditions on reservations and lack of culturally sensitive service resources to address the needs of these youth. Developmentally disabled youth are also at-risk when their problems are misdiagnosed or service responses to needs of the child or family are lacking.

Montana's 1990 census report indicates a population of 221,104 youth under 18 years of age. National prevalence rates applied to the youth population indicate as many as 31,500 youth have a diagnosable emotional disturbance classifiable under the DSM-III-R. Of this group, approximately 6000 meet the definition of severe emotional disturbance.

Of the estimated 6000 youth with severe emotional disturbance, 809 were identified by 127 of Montana's 546 local school districts in the 1991 school year. Indian Health Services have identified 141 youth with severe emotional disturbance

on six of seven reservations in the state. The Department of Family Services (DFS) is serving an estimated 847 SED youth within the child welfare service programs. At present time, the Department of Family Services has 63 of these youth in out-of-state residential treatment facilities. The Department estimates a minimum of 50% of these youth are severely emotionally disturbed.

In 1987, Montana incarcerated 20.5 youth per 10,000 population or 23.5% more than the national rate. Probation officers, courts, and other services providers maintain that a significant number of these are youth with severe emotional disturbance and have entered the juvenile system because of lack of community resources to meet their treatment needs.

## IV.4 Current System

In 1988 Montana's Title XIX Program (Medicaid), spent $900,000 on residential care. In 1989 this increased to over $7 million, and the cost has increased since 1989. DFS in fiscal year 1989 spent $1.1 million for out-of-state residential care and $2.9 million for in-state residential care for a total of $3.9 million.

In Montana today there are a variety of responses to the mental health needs of youth and their families. These responses range from using private practitioners (psychiatrists, psychologists, clinical social workers, professional counselors, ministers, drug and alcohol counselors), to public agencies (mental health centers, schools, Department of Family Services) and private in-patient psychiatric care and residential care facilities. However, with all these resources, Montana does not have a system of services which can fully respond to the service needs of youth and their families. Currently services are concentrated toward in-patient psychiatric and residential care rather than community-based family preservation and home-based services. Current services are not coordinated and require the child and family to fit into existing service definitions.

Montana has 5 community general hospitals that have licensed mental health units which may or may not serve youth. These are: St. James in Butte, St. Patrick's in Missoula, Deaconess in Billings, Deaconess in Great Falls, and St. Peter's in Helena.

In-patient psychiatric hospitals which are licensed to serve children in Montana include Rivendell of Billings licensed for 60 beds (actual beds available are 48), Rivendell of Butte licensed for 48 beds, and Shodair of Helena licensed for 22 beds. Rivendell of Butte has designated 10 beds for youth under 10 years and 38 for adolescents. Rivendell of Billings serves adolescents. Shodair serves youth 0-12 years of age.

Montana has a single residential treatment center, Yellowstone Treatment Center (YTC) of Billings (formerly Yellowstone Boys & Girls Ranch) with a current capacity of 78 beds for 6-18 year olds. In the past, this facility has had an average length in care of two years. YTC is currently undergoing program changes which will alter their target population. The Deaconess Home of Helena is currently licensed as a group home facility, but has many characteristics of a residential care facility. The Deaconess Home serves 30 youth 6-12 years of age and has an 18 month average length of stay.

Montana has several therapeutic group homes to provide services to adolescents with emotional disturbance. Horizon Home of Billings provides services to nine females who have been sexually abused. Youth Dynamics, Inc. of Billings and Bozeman provides group home services to ten dually diagnosed (developmentally disabled and emotionally disturbed) adolescents. Missoula Youth Homes, Inc. through their Talbot group homes provides services to sixteen adolescents with emotional disturbance. The AWARE program of Butte provides group home services to twelve youth who are dually diagnosed and emotionally disturbed youth. The REM Montana, Inc. program in Billings, through their Colton group home, provides services to four dually diagnosed adolescents.

Montana provides therapeutic foster care in several communities. Missoula Youth Homes, Inc. of Missoula provides this service to ten youth. Eastern Montana Community Mental Health Center of Glasgow provides therapeutic foster care to eight youth 3-17 years of age who have been sexually abused. Golden Triangle Community Mental Health Center of Great Falls provides a therapeutic program for 25 youth. Deaconess Home of Helena provides a therapeutic foster care program for six youth.

Services that are supportive of serving children and adolescents with severe emotional disturbance in their communities include the day treatment programs. Montana has four regional Community Mental Health Centers which, in cooperation with local school districts, provide adolescent day treatment services. Western Montana (Region V) Mental Health Center and the Missoula School District provide this program to 24 youth. Golden Triangle Community Mental Health Center (Region II) and the Great Falls School District provide day treatment to 24 adolescents. Mental Health Center (Region III) and the Billings school district provide services to 24 adolescents. Mental Health Services, Inc. (Region IV) and the Helena School District provide services to 24 adolescents. Day Treatment or partial hospitalization programs are also provided by St. Patrick Hospital of Missoula for eight youth, Deaconess Hospital of Billings for fourteen youth, and by Shodair of Helena for fourteen youth up to 15 years of age. Western Montana Mental Health Center and the Missoula Elementary School District provide day treatment services for eight youth from grades 1-6.

Montana's five Community Mental Health Centers provided out-patient services to 2999 youth in state fiscal year 1991. Children and adolescents with severe emotional disturbance are estimated to make up 50% of those served. Funding for these mental health services is provided by the Department through fee-for-service contracts. In addition to the centers, the Department also contracts with Friends To Youth of Missoula for services to SED youth between the ages of 10 - 18 years. Friends To Youth is a non-profit private service organization that serves approximately 100 youth a year of which approximately 25% are youth with severe emotional disturbance. The funding provided by the Department's Mental Health Division through these contracts for mental health services is $752,124. The services include individual and group therapy, counseling to parents, family therapy, case management, community consultation, and day treatment. In addition, the Mental Health Division provided $80,827 for mental health services through interagency agreements between local school districts and community mental health centers. The Division also provided $35,000 for the development of therapeutic foster care. This is a total of $867,951 for state fiscal year 1991.

The need for services is greater than currently available non-hospital or residential community care resources can provide. Therefore, Montana must target

its resources to address the youth and their families with the greatest need. At the present time the objective is to develop a system of care over the next decade capable of serving the estimated 6000 youth with severe emotional disturbance and their families.

## IV.5 System Components

The system of care needed to address the needs of severely emotionally disturbed children, adolescents and their families has nine components. These components are:

1. Mental health services
2. Social Services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Juvenile correction services
8. Operational services
9. Advocacy/Parent Advocacy

## IV.6 System of Care for 1990's

The 1990's challenge is to review, redesign, and implement a true mental health service system for youth and their families that is children and adolescent driven. The challenge requires that the service providers, regardless of the service, be appropriately trained to assure effective and efficient services.

In order to implement the system, a method of determining the resources and their distribution is necessary. North Carolina developed, tested, and utilized a service distribution formula. This formula was utilized along with the distribution formula recommended by Robert Friedman, Ph.D.

The formulas when applied to Montana's 1990 population establish the Department's service system objectives for development over the next decade. The development requires a planned approach based upon available resources, including both funding and trained staff. This requires use of demonstration models to establish cost and impact of the various services. The service capacities for Montana's system of services for severely emotionally disturbed youth are affected by the following considerations:

1) These are estimates of resources needed and may need to be modified to account for the rural nature of Montana.

2) The estimates are minimums.

3) The various resources are interdependent services. Therefore, failure to provide one or more means the others may have a corresponding increase in demand which alters the effectiveness of the system.

4) Resource availability is dependent on the prevalence of youth with severe emotional disturbance in the Montana population.

5) Initially the demand for the services may be heavy because of the backlog of unserved youth and families.

6) The number of "slots" reflects the capacity of the system in number of persons who can be served at any one time.

7) Regardless of service resources, the services need to be community-based, child-driven, and family-supportive.

## COMMUNITY-BASED NON RESIDENTIAL SERVICES

Home based: ---------- 442 slots

An intensive method of service delivery providing services in the home directed at preventing family dissolution. The service focuses on the family and is directed at strengthening the family by utilizing family members' strengths as basis upon which to build.

Respite Care for parents: ---------- 91 slots

A service provided by trained parent(s) who assume the duties of child caregiving and supervising for a planned brief period thereby providing the parent a break from the constant strain of parenting.

Case Management: ---------- 884 slots

A service provided by a single individual which includes coordinating and monitoring of a case plan; identification, location, and arrangement of services in response to identified needs for the child and family; and advocacy.

Day Treatment Services: ---------- 442 slots

A service that is frequently provided in a school setting and provides an integrated set of educational, counseling and family interventions which enable the youth to remain in the school and community.

Vocational:

Services directed toward gainful employment including career education, vocational assessment, job survival skill training, vocational skills training, work experience, job finding, retention services, and sheltered employment.

Vocational Education: ---------- 68 slots

Vocational Evaluation: ---------- 41 slots

Vocational Placement: ---------- 39 slots

Outpatient: ---------- 1769 slots

Services provided in a variety of community based settings including individual, group and family therapy; psychotherapy; chemotherapy; behavioral therapy; etc.

Parent Support Services: ---------- 177 slots

Services provided to enable parents to care for their child in their own home and/or to participate fully in the treatment of their child. Services may include parent training, parent counseling, parent aides/assistants in the home, homemakers services, etc.

## OUT-OF-HOME CARE

In-patient Hospital: ---------- See Below*

A service provided in a psychiatric hospital or a psychiatric unit of a community hospital which is used as short-term treatment and crisis stabilization for youth in acute distress, presenting a danger to him or herself or others.

In-patient Residential: ---------- See Below*

A service provided in a highly secure and licensed psychiatric facility which is not a psychiatric hospital or community hospital unit. Treatment is provided for a moderate to long-term time period. Services are provided within the confines of the facility and may include individual, group and family therapy, chemotherapy, education, behavior management, etc.

Therapeutic Group Care : ---------- See Below*

A mental health service which is provided in a home-like environment and may include all of the services of a residential care facility. The home may have from 2 to 12 youth residing in the home at one time. Supervision of the treatment is provided by a qualified mental health professional.

Therapeutic Foster Care : ---------- 111 slots

A service which provides treatment within the context of the treatment home with the foster parents serving as the primary therapists and supervision of the treatment provided by a qualified mental health professional. This service is limited to no more than 2 youth in the home at one time. Support services provided by community resources may include individual and group psychotherapy, chemotherapy, education, parent training, etc.

Supervised Independent Living: ---------- 8 slots

A transition service to assist in preparing youth to be able to live on their own including limited supervision of living arrangement and support services. The support services are to enable development of basic skills (e.g. apartment finding, opening checking accounts, budgeting, purchasing clothing, food, utilities, etc.).

* The Department believes there is a need for approximately 247 in-patient/residential/group care beds for children/adolescents with severe emotional disturbance. The number of beds in each of these three categories has not been calculated.

Although the above system is a suggested response to service needs of youth with severe emotional disturbance and their families, experience of other states and common sense indicates that these same services are beneficial to emotionally disturbed youth in general as well as youth "at-risk". These services serve as a means of early identification and intervention reducing the number of youth who become severely emotionally disturbed.

## IV.7 Role of the Mental Health Division, Department of Corrections and Human Services

The needs of children and adolescents with severe emotional disturbance are complex. The complexity of the service response dictates that no one agency or service provider can provide all the services the youth and his/her family need.

The role of the Mental Health Division, Department of Corrections and Human Services, is to facilitate a culturally sensitive, comprehensive, integrated and coordinated service response to identified needs of children and adolescents with severe emotional disturbance and to their families. The role includes seeking funding for pilot projects serving youth in their own community to demonstrate feasibility, cost, and replication potential; facilitating interagency agreements to assure community-based coordinated service planning and implementation at all government levels; and identifying, with the assistance of other State and local agencies, programs and methods to maximize current state and federal resources for serving children and youth with severe emotional disturbance. The Division also has responsibilities for funding selected components of the service system, assisting communities through technical assistance and consultation, collaborating with the various providers, and maximizing the role of parents, parent surrogates and advocates as partners in the planning of service systems.

# V. SERVICE SYSTEM FOR ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS

A major responsibility of the state and federally funded mental health system is the provision of treatment, support and advocacy for individuals with severe, disabling mental illnesses. Historically, this responsibility has been met by large state institutions where many mentally ill patients spent much or all of their lives. In recent years, society has become more sensitive to the civil liberties of people with mental illnesses. At the same time, advances in treatment techniques and approaches to community support have occurred. As a result, the great majority of individuals with severe, disabling mental illnesses can and should be served within Montana communities.

## V.1 Definition

The Department has defined an adult with a severe disabling mental illness as a person who is 18 years old or older and who meets criterion 1 and criterion 2.

Criterion 1 The person has a severe mental illness as indicated by one of the following:

a. the person has been hospitalized for at least 30 consecutive days because of a mental disorder at Montana State Hospital (Warm Springs campus) or Rivendell (former Montana Youth Treatment Center) at least once, or

b. the person has a DSM-III-R diagnosis of schizophrenic disorder (295), major mood disorder (296.2, 296.3, 296.4, 296.5, 296.6, 296.7, 301.13); paranoid disorder (297.10); organic disorder (293.81, 293.82, 293.83, 294.00, 294.80, 310.10); or other psychotic disorder (295.40, 295.70, 297.30, 298.90); pervasive development disorder (299.80) when not accompanied by mental retardation; or

c. the person has one of the following personality disorders: 301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.81, 301.82, 301.83, 301.84 or 301.90, which causes the person to be unable to work competitively on a full-time basis or unable to maintain a residence without assistance and support by family or a public agency.

Criterion 2 The person has ongoing functioning difficulties because of the mental illness, as indicated by one of the following:

a. medication has been prescribed to control the symptoms of mental illness, or

b. the person is unemployed or does not work in a full-time competitive situation because of mental illness, or

c. the person receives SSI or SSDI payments due to mental illness; or

d. the person maintains or could maintain a living arrangement only with the ongoing supervision and assistance of family or a public agency.

The purpose of this section of the Plan is to describe what the Department of Corrections and Human Services considers to be an adequate mental health system to meet the first part of its mission, a system which "provides treatment, rehabilitation and support services for psychiatrically disabled adults". The Department will use this "vision" of a fully developed system to guide planning and program development activities over the coming years. The goals in this Plan are designed to move the system toward its vision.

## V.2 Values

The system toward which the Department wishes to move is based upon the following Statement of Principles:

1. Services should be based on the needs of consumers rather than the needs of the system, the Department or mental health providers. No system can provide the optimal set of services for every consumer; however, a consumer's needs must be the predominant factor in planning services. Services should also incorporate consumer self-help approaches and be provided in a manner that promotes consumers retaining the fullest possible control over their own lives.

2. Services should be flexible and allow for the special needs of both individuals and subgroups of consumers. Programs should be developed or adjusted to meet the special needs of such subgroups as Native Americans and other ethnic minorities, the elderly, and mentally ill people who are also mentally retarded, chemically dependent or homeless.

3. Services should be offered in the least restrictive, most natural and least disruptive setting possible. Consumers and families should be encouraged to use the natural supports in their community and should be integrated to the greatest extent possible into the normal living, working, learning and leisure time activities of the community.

4. Services should be built on the assets and strengths of consumers to help them maintain a sense of identity, dignity, self esteem and independence.

5. Services should seek to prevent consumers from harming themselves or others and from being harmed by members of the community.

6. Service systems funded by the Department should be accountable to the users of the services. The needs, preferences and rights of consumers should be of major importance in planning and operating the mental health system. Consumers should be involved in the decision making process as individuals at the treatment level and collectively at the systems level.

7. Effective service systems are dependent on sufficient numbers of competent, motivated, sensitive and caring staff. The availability, distribution, competence, training and appropriate utilization of staff are among the most critical issues which should be addressed by the mental health system.

These principles define the Department's philosophy in fulfilling its mission. While it is important to have a philosophy, it is not always easy to use that

philosophy to guide choices which have to be made as a system of services is built. The following continuum demonstrates how the Department's statement of principles can be operationalized. The Department's philosophy implies that services should be developed which more closely resemble those listed in the right hand column rather than those in the left hand column.

| | |
|---|---|
| Sheltered workshops | Supported or competitive work in various job settings |
| Traditional day treatment | Club houses, drop-in centers, and assistance in daily living activities |
| Inpatient placement as first or preferred choice in crisis situations | Inpatient deflection through crisis response services, mobile outreach, crisis beds, and crisis care homes |
| "Aftercare" group homes and residential settings | Independent living, with staff who "come in" (not "live in") |
| Office-based treatment where persons with serious mental illness come in for appointments | Staff going where persons with serious mental illness are, and assisting them in daily living activities and community integration |
| Case management with high consumer to staff ratios, and low case manager funding authority or flexibility | Intensive case management with low (e.g., 10-12:1) consumer-to-staff ratios |
| Service design guided by existing facilities, funding, and programs. | Service design guided by family and consumer input, staff skills, and "least restrictive and most appropriate and economical" policies |

## V.3 Ideal Service System

The Mental Health Division of the Department of Corrections and Human Services proposes a Comprehensive Treatment and Support System (CTSS) for adults with severe and disabling mental illness. The CTSS will consist of the ten community support system components defined by NIMH:

1. Client Identification and Outreach
2. Mental Health Treatment
3. Crisis Response Services
4. Health and Dental Care
5. Housing
6. Income Support and Entitlements
7. Peer Support
8. Family and Community Support
9. Rehabilitation Services
10. Protection and Advocacy.

These ten components will be coordinated by case managers and made available throughout Montana in larger communities. It is anticipated that community-based CTSS services will be provided or coordinated through regional community mental health centers (CMHCs). The CMHCs have the capacity to implement the Department's policies with regard to CTSS development. Other providers will be used if a CMHC is unable or unwilling to develop the needed services. The Montana State Hospital and the Montana Center for the Aged are part of the CTSS, providing specialized treatment services which are not available in communities.

The Mental Health Division of the Department of Corrections and Human Services is responsible for the development and effective operation of the CTSS. Division staff will monitor services provided by each regional CTSS and develop methods to identify unmet needs with the service areas. Division staff will also develop the expertise to serve as statewide consultants in areas such as Medicaid, housing programs, vocational rehabilitation, Social Security benefits and workforce development.

The CTSS will be supported by State laws which guarantee consumer rights, focus funding on CTSS services and emphasize less restrictive, community-based services whenever possible. The mental health "commitment" law will require that all involuntary commitments are made to local CTSS provider agencies with a determination made at that level whether institutional services are needed. Voluntary admissions directly to the Montana State Hospital (MSH) will be discontinued. Consumers will be voluntarily admitted to MSH only if referred by a community-based CTSS agency.

It is unrealistic to plan for a fully developed CTSS in all or even most Montana communities. The Mental Health Division has designated counties of less than 10,000 population as "rural" counties. Thirty-five of Montana's 56 counties are rural by this definition. Of the 21 counties with more than 10,000 people, 11 have more than 15,000 and 7 have over 20,000 population.

Despite representing a minority of counties, however, the non-rural counties contain 82 percent of the State's population and account for 88 percent of the admissions to Montana State Hospital. It is proposed that the CTSS be developed in Montana's non-rural counties. Case management will be available in all counties and some rural counties will have some CTSS components, but fully comprehensive services in all counties of more than 10,000 will meet the needs of the great majority of Montanans with severe and disabling mental illness.

The base upon which the system of services will be built is case management services. It is estimated that there are 6,000 adults in Montana with severe and disabling mental illness. Some of these individuals do not want or need case management services during certain periods of their lives. As a result, it is estimated that 80 percent or 4,800 adults with severe mental illness are in need of intensive or supportive case management at any given time in Montana.

Montana has adopted a modified "strengths" model of case management. Intensive case management, with caseload sizes ranging from 1-20, is a consumer driven service which includes:

- consumer identification and outreach
- individual assessment
- direction plan development
- linkage with existing services
- monitoring
- advocacy
- crisis assistance
- support in daily living
- network development

Supportive case management is a consumer driven service involving caseloads of from 20-40 clients. The services available through supportive case management are:

- individual assessment
- direction plan development
- linkage with existing services
- monitoring
- advocacy

Montana should have a case management system which provides intensive case management to 50 percent of mentally ill adults needing case management and supportive case management for the other 50 percent. With an overall average caseload size of 25, Montana's mental health system should have 190 case managers for adults with severe and persistent mental illness.

Expanding case management services from the 1992 level of approximately 50 FTE to 190 represents a very substantial increase in this service. This increase is justified by the growing realization, in Montana and nationally, that good case management services are a key to assuring appropriate services in the least restrictive setting. In Montana a considerable amount of what constitutes case management is done by other staff in day treatment, group home and therapy settings. The expansion of case management may, therefore, be accomplished to some extent by shifting of resources currently used for other services.

A brief description of each of the 10 CTSS components follows. It is important to recognize the importance of education as a CTSS activity within many if not all of the ten components. Education of the consumer, his or her family and the community is a necessary ingredient for effective treatment, rehabilitation and support. The case management function itself is in large part an educational one.

Mental Health Treatment of Mental Illness

Treatment and related services include education/information, medication management, psychotherapy, day treatment, and inpatient services.

In all communities, regardless of what other services are being utilized by an individual, the mental health agency should provide to the individual and his/her family relevant information on such topics as the individual's specific mental illness, symptoms, and medications. Such information should be provided in a systematically and carefully prepared manner in order to maximize its usefulness.

All adults with severe and disabling mental illness should have available a physician who is knowledgeable in the use of psychotropic medications. Ideally, this service should be provided by a psychiatrist. Where psychiatrists are not available other physicians may be used. The system should provide for consultation (by long distance telephone if necessary) for non-psychiatric physicians with psychiatrists. Each community which has a day treatment program should have medication review services as part of that program.

The role and importance of psychotherapy as a treatment modality for people with severe and disabling mental illness is a topic of some controversy. Most would agree that it should not be the only or the primary service but that it should at least be available to those who want and need it. The emphasis should be on short term psychotherapy to deal with specific issues although longer term therapy is appropriate in some cases. To the extent that psychotherapy provides a supportive relationship and assistance in setting life goals, case management may help to reduce the demand for these services.

Day treatment has been the core of alternative treatment services in Montana. In a sense, day treatment is not a distinct service, but rather a setting in which individual and group psychotherapy, rehabilitation, consumer education, social support, case management, crisis intervention and medication management services have taken place. Providing these services under one roof is convenient for consumers and staff and it greatly facilitates the coordination of the service components. This arrangement also helps develop a feeling of "community" among consumers and staff and facilitates the understanding and acceptance of a program's philosophy and mission. On the other hand, this kind of service model may not encourage integration of the consumer into the community and may not serve a consumer who wants and needs certain components of the program but who does not wish to become a "member" of the day treatment center.

The CTSS to be developed will include all of the components which are now part of the day treatment programs without requiring that those components be combined within a day treatment program. A fully developed case management program will provide the coordination which is one of the benefits of combining the components under one roof. The intent is not to discontinue day treatment if that model of service is needed and desired, but to provide the option for service providers and consumers to offer and receive the services which constitute day treatment in a less centralized way.

There are 60 licensed hospitals in Montana. Of these, six are general hospitals which have distinct psychiatric units. In addition to Montana State Hospital, there are four free-standing psychiatric hospitals, three of which are exclusively for children and/or adolescents. To provide adequate inpatient treatment services, Montana's hospital resources must be better utilized.

The primary role of community hospitals in the mental health system is to provide short term stabilization of acute psychotic episodes when non-hospital crisis service are not sufficient or not available. All licensed general hospitals must be able and willing to admit an acutely psychotic person at least for a 24-hour period for stabilization and referral to a more specialized inpatient facility. General hospitals of 40 or more beds should have at least one room appropriately designed for psychiatric patients and the ability and willingness to provide inpatient care for several days. Free-standing psychiatric hospitals and general hospitals with psychiatric units must be able to provide longer term (up to 21 days) acute services.

The Montana State Hospital (MSH) is a major treatment resource for people with serious mental illness. As a more adequate system of services is developed, the role of MSH will change. Its role should not, however, be determined by default. Part of the process of developing the system of services is defining the role of MSH and providing the facility and staff to meet that role. In a fully developed CTSS the role of Montana State Hospital will be to serve persons in acute phases of their illness who have serious disorganization of thought processes and are unable to understand or safely deal with the realities of everyday life. The primary function of the Hospital will be treatment of acute episodes which have not been effectively stabilized via crisis intervention services or short term inpatient hospitalization in the

community. MSH will also serve people who, on a chronic basis, continue to exhibit behaviors and symptoms which constitute a danger to self or others.

It is anticipated that the patient population of MSH will be reduced although the full extent of that population reduction is not known. Moreover, the population served will be limited to adults with mental illnesses requiring extended inpatient services to achieve stabilization. Appropriate alternatives in the mental health system or in other human service programs will be developed for other people who are sometimes admitted to MSH.

The Montana Center for the Aged provides nursing care and mental health services for older people who have mental illnesses and who require nursing home services. The Center for the Aged provides a more intensive mental health program than is found in most nursing homes. It does not, however, provide acute inpatient treatment such as is provided at MSH.

Crisis Response Services

Aside from case management, the service needing most extensive development in Montana is crisis intervention. All counties with a population of greater than 10,000 will have a crisis/transition team. This team will have the following duties:

1) Availability to respond to psychiatric crises 24 hours per day. This includes telephone response, mobile outreach, and walk-in services.

2) Close liaison with local law enforcement including training of jail personnel in identifying people with mental illness.

3) Intensive transitional (1-30 days) case management of persons leaving MSH and other inpatient units

4) Twenty-four hour crisis services to adjacent smaller counties including telephone response and, to the extent possible, mobile outreach.

Each team will have available non-hospital settings (e.g., an apartment or house) in which to provide short term residential crisis services. The team will also have the capacity to provide crisis stabilization services in consumers' homes for a short term (several days) basis.

All counties will have 24-hour emergency telephone services.

Health and Dental Care

It is an important responsibility of case managers to assure that consumers have access to appropriate medical and dental care. Case managers must help consumers recognize health problems, make appointments, and provide or arrange transportation to medical and dental services.

Case managers also have an educational role to play with regard to health and dental care. Information about preventative health practices and symptoms of physical illness should be communicated. An especially important role for case managers is the provision of instruction on the nature of the consumer's mental illness and the effects and side effects of psychotropic medication. Finally, information on issues of sexuality, birth control and sexually transmitted diseases should be available to consumers from case managers.

Housing

A fully developed comprehensive treatment and support system will not require additional group home programs. Housing, whenever possible, will be provided in regular apartments and houses with consumers living alone or with others of their choice and with necessary support provided by case managers. Low income consumers will receive subsidized housing. Group and clustered living arrangements will be available as an option, but the goal is to integrate as many people with mental illness as possible into normal housing arrangements with support as needed.

Income Support and Entitlements

The Medicaid program will be changed so that rehabilitation services for the severely mentally ill are reimbursable. Reimbursement for case management would provide funding for approximately half of the case managers needed in Montana. Replacing the clinic services option with the rehabilitation option gives better flexibility in meeting treatment needs outside of facility-based day treatment programs.

Case managers, working with MSH staff will assure that consumers being discharged from the State Hospital have applied for SSI benefits before discharge, if appropriate.

Administrative Rules will be amended to entitle all consumers who are receiving comprehensive treatment and support system services to the SSI state supplement.

Peer Support

Counties with populations of more than 10,000 will have some kind of organized peer support services. The exact nature of those services (e.g., group support meetings, drop-in center, or crisis services) will depend on the interests of consumers in each community.

Family and Community Support

In counties with more than 10,000 population, the comprehensive treatment support system will include weekly "crisis" groups for family members of consumers who are experiencing crises. The system will also include ongoing support/ instructional sessions for family members on topics such as:

- Consumer Independence from Family
- Coping with Chronic Illness of Family Member
- Medications
- Stigma of Mental Illness
- Consumer and Family Rights

- The Mental Health System
- Stress Management

Rehabilitation Services

Each CTSS community will have rehabilitation services which include the following:

- Vocational/Career Planning
- Pre-employment Training/Skill, Attitude and Endurance Building
- Assistance in Job Seeking
- Temporary Employment Placements
- Supported Employment
- Post Employment Follow-along and Support
- Supported Education
- Support in Activities of Daily Living
- Support in Socialization Activities

To the extent possible, Vocational Rehabilitation (VR) funding will be used for vocational services. Case managers will work closely with VR counselors, generic VR providers and mental health rehabilitation programs to coordinate services on a long term basis for consumers.

Protection and Advocacy

The Department will thoroughly pursue all recommendations made by the Mental Disabilities Board of Visitors in its reports. The Department will ensure that each cited deficiency has been corrected or that the reason no action is taken has been fully justified.

In a rural state like Montana it makes sense to have the lead community CTSS agency provide case management, especially since the model of case management is more than simply that of brokering services. There is a danger, however, that the very important advocacy role of case managers can be compromised if the lead agency does not allow the case managers the independence to freely represent the consumers

in obtaining desired services. Agencies which provide case management will have policies and procedures in effect to ensure independence of case managers.

The Department will monitor grievances by consumers in community programs and the State Hospital and intervene when necessary.

Identification and Outreach

Identification and outreach is a case management function. The CTSS will be based on a "zero reject, zero eject" policy which is designed to provide services to even the most disabled and challenging consumers. CTSS staff (case managers and crisis/transition staff) will maintain liaison with jails and homeless shelters. All community agencies will be aware of CTSS services which are available. All voluntary and involuntary admissions to MSH will be accomplished through community-based CTSSs.

In order to locate and engage the number of people with severe and disabling mental illness believed to be in Montana, assertive outreach activities must be an important part of case managers' duties. Case managers will also maintain contact with consumers who are hospitalized locally or at MSH and be responsible for having in place the needed services and supports at discharge.

## V.4 Specific Services for an Ideal System

A Committee of the State Mental Health Planning and Advisory Council has worked to operationalize this "ideal" system described in the previous section. The following shows an estimate of the specific services which are needed to fully implement the "vision".

| SERVICE | PERCENT OF POPULATION | NUMBER SERVED | NUMBER OF LOCATIONS | NOTES |
|---|---|---|---|---|
| 1) TREATMENT (OUTPATIENT) | | 4811 | | Assumption: 80% of Estimated population of SDMI will need serices from the public mental health system |
| A. Education | | | | |
| Classes | | | 10 | Orientation classes, 12 week modules, 1per wk, 1 staff |
| Written Materials | | | | Development / printing costs; annual costs are for updating and distribution. |
| B. Medication Mgmt. | | | | |
| Medication Groups | 50.0% | 2406 | 39 | Weekly groups staffed by an RN, at every CMHC office |
| M.D. | 100.0% | 4811 | | Monthly medication checks by an M.D. |
| Emerg Medications | | | | |
| C. Psychotherapy | | | | |
| Individual | 20.0% | 962 | | |
| Groups (BPD) | | 72 | 9 | Groups meet 3X per week, 8 clients per group, reimbursement @ |
| Staff Training | | | 9 | $16.00 per client. Training for staff of BPD groups estimated at $800 annually per site. |
| 2) CRISIS RESPONSE | | | | |
| A. Crisis Intervention | | | | |
| Butte/Billings | | | 2 | Annual Cost per site @ $436,000, 8 beds (Butte Model) |
| Other Ctys >20,000 | | | 7 | Annual Cost per site @ $280,000, (Kalispell Model) |
| B. 24 Hour Telephone | | | | |
| C. Admitting Professionals | | | | |
| Screening Costs | | | | |
| D. Short Term Inpatient | | | | |
| Community Hospitals | | | | 10 Beds across state;173 persons could be served with an average LOS of 21 days |
| | | | | |
| 3) CASE MANAGEMENT | | | | |
| A. Case Managers | | | | |
| Intensive Case Mgmt | 50% | 2406 | | Caseloads of 1-20 |
| Supportive Case Mgmt | 50% | 2406 | | Caseloads of 21-40 |
| B. Training of CM | | | | |
| Conference | | | | |
| Training Materials | | | | |
| C. Resource Manual | | | | |
| Development | | | | Development of Manual/ Printing & Distribution |
| Annual Updates | | | | |

| SERVICE | PERCENT OF POPULATION | NUMBER SERVED | NUMBER OF LOCATIONS | NOTES |
|---|---|---|---|---|
| 4) HOUSING | | | | |
| A. Group Homes | | | | 100 Beds (Current number) |
| Group Homes (Elderly) | | | 3 | Three group homes of 8 beds (New) |
| B. Clustered Living | | | | |
| Transition Beds | | | 9 | One apt at each location as a transition bed |
| Managers | | | 9 | Rent cost for apartment managers at 9 sites. |
| Emergency Funds | | 200 | | Funds available to assist clients with rent deposits, furnishings and emergencies |
| C. Housing Specialist | | | | Department Staff position to provide technical assistance |
| 5) PEER SUPPORT | | | | |
| Drop-in Centers | | | 12 | Located in counties >20,000 population |
| 6) FAMILY SUPPORT | | | | |
| A. Education | | | | |
| Classes for Families | | | 9 | Classes in 12 wk modules; located in counties >20,000; meet 1 X per week |
| Written Material | | | | Develop catalogue of support services, info about mental illness. |
| Consultation w/ Prof Grps | | | | |
| Presentations | | | 5 | CMHC staff time working with Attorneys/Physicians/Judges/Law Enforcement. |
| Written Materials | | | | Materials for distribution to Attorneys/Physicians/Judges/Law Enforcement |
| Conference | | | | Presentations at conferences of State organizations of groups cited above |
| B. Toll Free Telephone # | | | | Assumes volunteers will coordinate an answering service |
| C. Respite Workers | | | 10 | On call pool of aggregate of 1.0 FTE in Counties >15,000 |
| Recruitment & Trng | | | 10 | Assumes 2 training sessions of 20 Hours annually at each site. |
| 7) REHAB SERVICES | | | | |
| A. Employment | | | | |
| Pre-employment | 20% | 674 | | Assumes 20% of Unemployed SDMI will be in "pre-employment". |
| Work Adjustment | 30% | 1010 | | Assumes 30% of Unemployed SDMI will be in "Work Adjustment" programs |
| Supported Employment | 30% | 1010 | | Assumes Staff/client ration of 1:5; 187 Job Coaches |
| B. Supported Education | | | | Case Management Function |

| SERVICE | PERCENT OF POPULATION | NUMBER SERVED | NUMBER OF LOCATIONS | NOTES |
|---|---|---|---|---|
| C. ADL Classes | 70% | 3368 | | Estimated 70% of SDMI clients seeking state services will need 2-4 hours per week of ADL classes |
| D. Socialization Activities | 80% | 3849 | | Four hours per week for 80% of SDMI clients. |
| | | | | |
| 3) PROTECTION & ADVOCACY | | | | No costs associated with implementation activities. |

## V.5 Current System for Adults with Severe and Disabling Mental Illness

Region I comprises the eastern-most seventeen counties of Montana. This is a huge land area (47,747 square miles) with a small population: about two people per square mile. The largest communities in Region I have populations of approximately 10,000 people. The Eastern Montana Community Mental Health Center (EMCMHC) is the agency responsible for public community mental health services in Region I.

EMCMHC offers some level of services in sixteen counties, although, in a number of communities services are provided on a part-time basis by staff traveling from other counties. Day Treatment services for adults with severe mental illness are provided in Miles City, Glendive, and Sidney. A residential (group home) program is located in Miles City.

The Center has limited intensive case management services in Miles City, Glendive, and Sidney. Case management is being expanded during FY 92 with the adoption of targeted case management under Medicaid. Supportive case management is provided by therapists for consumers who are not served by intensive case managers.

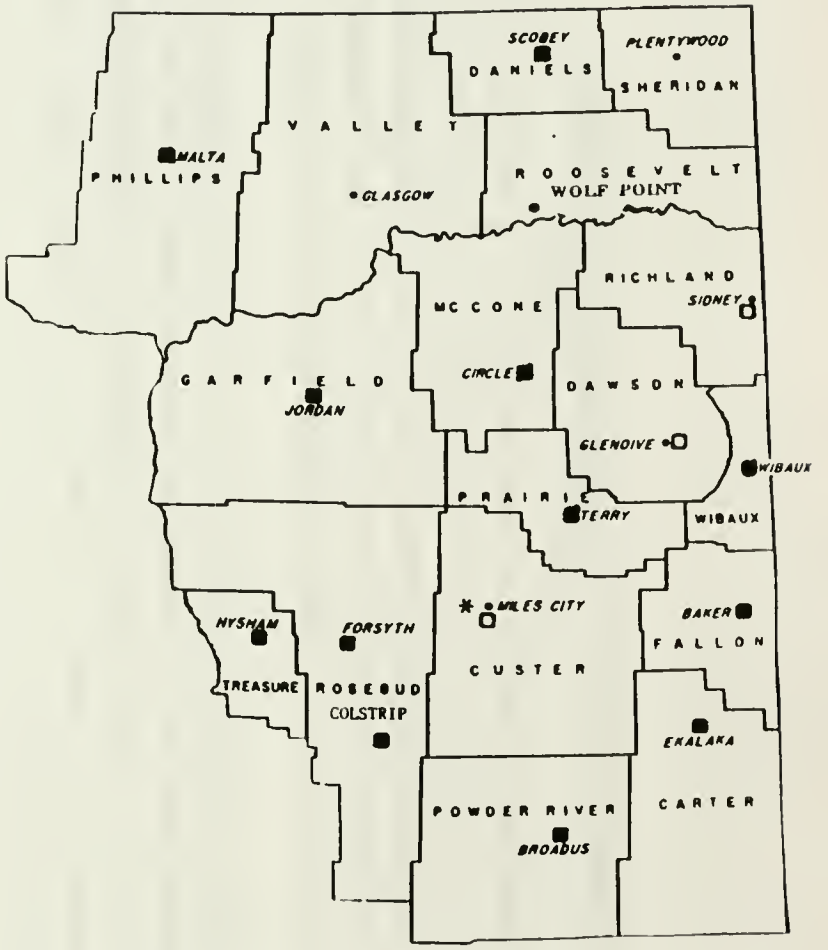
There are no hospitals in Region I with psychiatric units. The nearest acute psychiatric hospital care is provided in Billings, and in North Dakota hospitals. Similarly, there are no psychiatrists living in the region. Medical management of people with mental illness is provided, therefore, by primary care physicians.

The EMCMHC and the State Vocational Rehabilitation Program have an agreement to coordinate supported employment services for three clients in Miles City. Such agreements do not exist in other Region I counties.

The absence of inpatient psychiatric programs and psychiatric physicians constitutes a major gap in services in Region I. Ongoing medical management of mental illness as well as acute crisis response capacity is problematic.

# REGION I COMMUNITY MENTAL HEALTH CENTER

| REGION I CMHC | | |
|---|---|---|
| ESTIMATED NUMBER OF SDMI | | 661 |
| NUMBER SERVED IN FY 1991 | | 509 |
| PERCENT OF TOTAL RESOURCES EXPENDED ON SDMI | | 43.4% |
| PERCENT OF CASELOAD WITH DIAGNOSIS OF SCHIZOPHRENIA OR MAJOR MOOD DISORDER | | 22.0% |
| **SERVICES** | **AVAILABILITY** | **# SERVED** |
| DAY TREATMENT | 3 Locations | 154 |
| RESIDENTIAL | 12 Beds | 38 |
| SUPPORTED EMPLOYMENT | | |
| Voc Rehab Funded | Not Inhouse | 0 |
| Extended Services | 3 Slots | N/A |
| INTENSIVE CASE MANAGEMENT | 2 Case Managers | 112 |
| OUTPATIENT COUNSELING AND EMERGENCY SERVICES | 15 Counties | 1923 |
| ADMISSIONS TO MONTANA STATE HOSPITAL PER 10,000 POPULATION | | 3.19 |




- ● Full-Time Out Patient Clinic
- ■ Part-Time Out Patient Clinic
- ○ Day Treatment Programs
- * Transitional Living Programs

The EMCMHC has a serious problem in recruiting mental health professionals to eastern Montana. This is especially difficult when trying to staff programs in the many very small communities in the Region.

The range of vocational services available for adults with mental illnesses is another area in which expansion is needed. The existing day treatment programs do not have a strong vocational focus and there is limited involvement of vocational rehabilitation in the mental health system.

Region II is a nine-county area in northcentral Montana. Great Falls is the largest metropolitan area in the Region. The community of Havre is also in Region II. The Golden Triangle Community Mental Health Center (GTCMHC) serves the Region. Great Falls has a well-developed community support system under the leadership of GTCMHC. The New Directions program encompasses a well-coordinated program of day treatment, intensive case management, psychotherapy, medication management, supported employment and residential (group home and semi-independent) services. Psychiatrists employed by GTCMHC admit patients to the inpatient unit at Deaconess Medical Center.

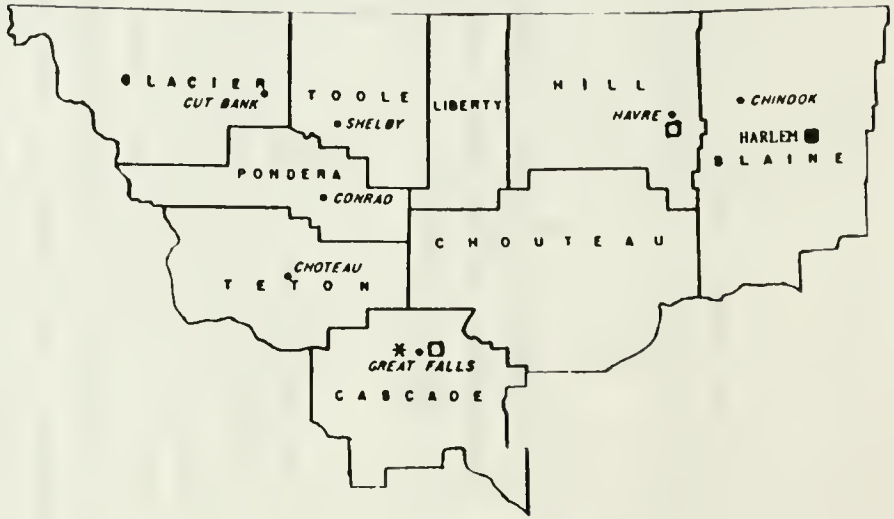
The GTCMHC provides day treatment, psychotherapy and intensive case management in Havre and offers psychotherapy and supportive case management in other smaller communities in the Region. Medication review is done by Great Falls-based psychiatrists on a consulting basis to the smaller satellite offices.

One feature of the GTCMHC program is that it has not only organized the Great Falls community into an effective system of support, it has also developed an effective system for referring consumers needed more intensive services from outlying areas to Great Falls.

Like other areas of the State, Region II needs a more fully developed crisis response capability, particularly in the smaller communities of the Region. Consumer run support services are just being initiated in Great Falls.

# REGION II COMMUNITY MENTAL HEALTH CENTER

| REGION II CMHC | | |
|---|---|---|
| ESTIMATED NUMBER OF SDMI | | 1129 |
| NUMBER SERVED IN FY 1991 | | 1017 |
| PERCENT OF TOTAL RESOURCES EXPENDED ON SDMI | | 62.3% |
| PERCENT OF CASELOAD WITH DIAGNOSIS OF SCHIZOPHRENIA OR MAJOR MOOD DISORDER | | 39.0% |
| **SERVICES** | **AVAILABILITY** | **# SERVED** |
| DAY TREATMENT | 2 Locations | 361 |
| RESIDENTIAL | 24 Beds | 36 |
| SUPPORTED EMPLOYMENT | | |
| Voc Rehab Funded | Inhouse | 18 |
| Extended Services | 6 Slots | N/A |
| INTENSIVE CASE MANAGEMENT | 5 Case Managers | 179 |
| OUTPATIENT COUNSELING AND EMERGENCY SERVICES | 8 Counties | 2088 |
| ADMISSIONS TO MONTANA STATE HOSPITAL PER 10,000 POPULATION | | 2.58 |




- ● Full-Time Out Patient Clinic
- ■ Part-Time Out Patient Clinic
- □ Day Treatment Programs
- * Transitional Living Programs

Region III is located in southcentral Montana and includes Billings, Montana's largest city. The Region also includes Lewistown and encompasses a total of eleven counties. This Region is served by the Mental Health Center.

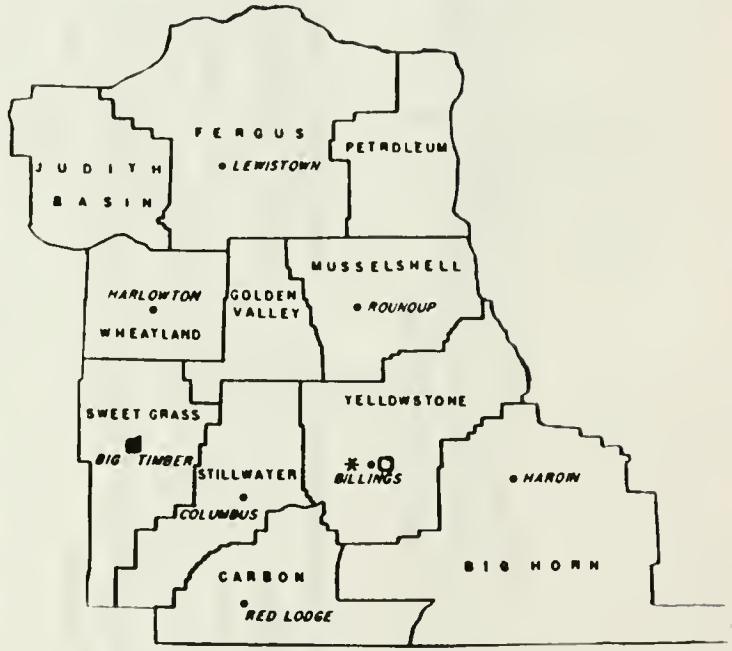
The Center provides comprehensive services in Billings including psychiatry, psychotherapy, day treatment (separate "acute" and "chronic" programs), residential and intensive case management. The Center has a good cooperative relationship with vocational rehabilitation providers which allows for a range of vocational service options. The Billings Deaconess Hospital has a large psychiatric unit which provides short term inpatient care.

The Center provides psychotherapy services in other communities in the Region. The psychiatric staff of the Center travels to outlying communities for medication monitoring. Intensive case management is not available outside Billings. Adults with severe mental illness receive case management from outpatient therapists.

Despite a well developed range of services provided by the Center and the availability of substantial community resources in Billings (private practitioners, hospital, vocational services, etc.) the State Hospital admission rate from Region III is relatively high, indicating that further community support system development is necessary. Intensive case management and crisis intervention which more assertively seeks alternatives to institutionalization are among the system development issues for Region III.

# REGION III COMMUNITY MENTAL HEALTH CENTER

| REGION III CMHC | | |
|---|---|---|
| ESTIMATED NUMBER OF SDMI | | 1176 |
| NUMBER SERVED IN FY 1991 | | 823 |
| PERCENT OF TOTAL RESOURCES EXPENDED ON SDMI | | 64.0% |
| PERCENT OF CASELOAD WITH DIAGNOSIS OF SCHIZOPHRENIA OR MAJOR MOOD DISORDER | | 38.0% |
| **SERVICES** | **AVAILABILITY** | **# SERVED** |
| DAY TREATMENT | 1 Location | 254 |
| RESIDENTIAL | 24 Beds | 72 |
| SUPPORTED EMPLOYMENT | | |
| Voc Rehab Funded | Not Inhouse | 0 |
| Extended Services | 8 Slots | N/A |
| INTENSIVE CASE MANAGEMENT | 4 Case Managers | 126 |
| OUTPATIENT COUNSELING AND EMERGENCY SERVICES | 10 Counties | 2068 |
| ADMISSIONS TO MONTANA STATE HOSPITAL PER 10,000 POPULATION | | 5.71 |




- ● Full-Time Out Patient Clinic
- ■ Part-Time Out Patient Clinic
- O Day Treatment Programs
- * Transitional Living Programs

Region IV is a twelve-county area in southwestern Montana. It includes the cities of Helena, Butte and Bozeman. The Region's community-based mental health provider is Mental Health Services, Inc. (MHS).

MHS provides psychotherapy, day treatment, intensive case management and residential (group home) services in Helena. St Peter's Hospital in Helena has a psychiatric unit but because MHS does not employ any psychiatrist, utilization of that unit is a problem.

In Butte, MHS offers psychotherapy, day treatment, intensive case management and short-term crisis intervention in a residential setting. St. James Hospital has a psychiatric unit although the situation in Butte is similar to that in Helena -- MHS does not employ a psychiatrist.

Bozeman has only recently begun a public mental health program as part of the MHS system. There is a small day treatment program, intensive case management and psychotherapy available. Bozeman does not have an inpatient psychiatric unit.

Other communities in Region IV have MHS program components, primarily psychotherapy services. MHS operates a small day treatment program in Dillon and during FY 92 is expanding intensive case management services into Powell and Deer Lodge counties.

Effective crisis intervention services are not in place in Helena and should be improved region-wide. The lack of psychiatric services within the publicly funded community support system is a serious problem for Region IV. The admission rate of Region IV residents to the State Hospital is extraordinarily high. This undoubtedly is, in part, because the State Hospital is located within the Region. It is particularly important that agencies within the catchment area, under the leadership of MHS, take a very assertive approach to planning, developing and providing alternatives to institutionalization. Pre-admission screening and State Hospital discharge procedures are two mechanisms to help in this process.

# REGION IV COMMUNITY MENTAL HEALTH CENTER

| REGION IV CMHC | | |
|---|---|---|
| ESTIMATED NUMBER OF SDMI | | 1442 |
| NUMBER SERVED IN FY 1991 | | 589 |
| PERCENT OF TOTAL RESOURCES EXPENDED ON SDMI | | 60.3% |
| PERCENT OF CASELOAD WITH DIAGNOSIS OF SCHIZOPHRENIA OR MAJOR MOOD DISORDER | | 26.0% |
| **SERVICES** | **AVAILABILITY** | **# SERVED** |
| DAY TREATMENT | 5 Locations | 411 |
| RESIDENTIAL | 16 Beds | 80 |
| SUPPORTED EMPLOYMENT | | |
| Voc Rehab Funded | Inhouse | 25 |
| Extended Services | 8 Slots | N/A |
| INTENSIVE CASE MANAGEMENT | 4 Case Managers | 101 |
| OUTPATIENT COUNSELING AND EMERGENCY SERVICES | 11 Counties | 1853 |
| ADMISSIONS TO MONTANA STATE HOSPITAL PER 10,000 POPULATION | | 8.89 |

- ● Full-Time Out Patient Clinic
- ■ Part-Time Out Patient Clinic
- ○ Day Treatment Programs
- * Transitional Living Programs

The seven western-most counties of Montana comprise Region V. This is the smallest region in land area and the largest in population. The population density is more than ten people per square mile.

Region V is served by Western Montana Community Mental Health Center (WMCMHC). The Center has worked toward providing a comprehensive service system in Missoula and Kalispell. Both communities have psychotherapy, day treatment, intensive case management, psychiatric services and residential (group home and semi-independent living) services. St. Patrick's Hospital in Missoula has a psychiatric unit which is accessible to community support system consumers. Inpatient psychiatric services are available to Kalispell residents only at a private free-standing psychiatric hospital, Glacier View.

Inpatient care at Glacier View is not reimbursable by Medicaid and is, therefore, largely unavailable to indigent patients. Kalispell does have a crisis response team which is funded on a pilot basis and which has a safe house available to house consumers in crisis who cannot remain in their own homes.

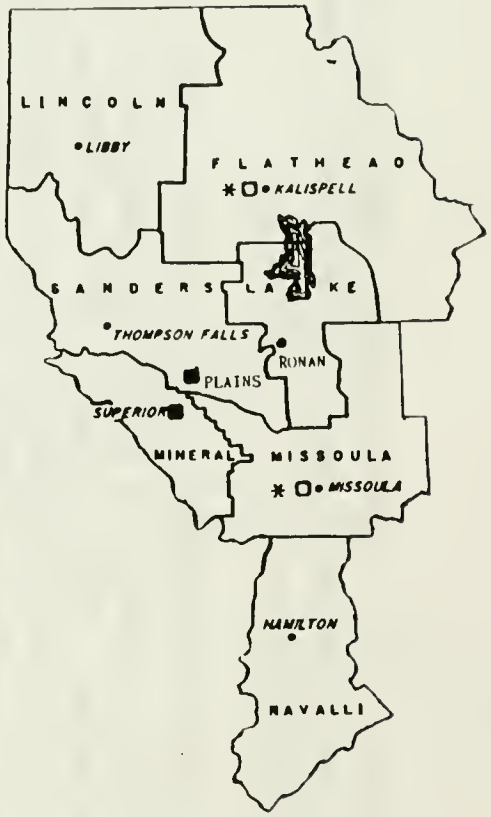
WMCMHC provides psychotherapy and is currently developing intensive case management services in the other five counties of Region V. The Center also provides some medication monitoring to outlying communities by psychiatrists who travel from Missoula and Kalispell. The Center purchases residential (group home) services from a program which operates in Stevensville.

A pilot program to assist long-term State Hospital patients to re-enter the community through very intensive case management services is offered in Missoula by WMCMHC.

The Region V service system is undergoing substantial growth and development. Areas of services which need further refinement include crisis intervention services and more complete pre-admission screening of State Hospital referrals.

# REGION V COMMUNITY MENTAL HEALTH CENTER

| REGION V CMHC | | |
|---|---|---|
| ESTIMATED NUMBER OF SDMI | | 1606 |
| NUMBER SERVED IN FY 1991 | | 598 |
| PERCENT OF TOTAL RESOURCES EXPENDED ON SDMI | | 62.7% |
| PERCENT OF CASELOAD WITH DIAGNOSIS OF SCHIZOPHRENIA OR MAJOR MOOD DISORDER | | 36.0% |
| **SERVICES** | **AVAILABILITY** | **# SERVED** |
| DAY TREATMENT | 2 Locations | 344 |
| RESIDENTIAL | 52 Beds | 122 |
| SUPPORTED EMPLOYMENT | | |
| Voc Rehab Funded | Inhouse | 35 |
| Extended Services | 9 Slots | N/A |
| INTENSIVE CASE MANAGEMENT | 7 Case Managers | 169 |
| OUTPATIENT COUNSELING AND EMERGENCY SERVICES | 7 Counties | 1734 |
| ADMISSIONS TO MONTANA STATE HOSPITAL PER 10,000 POPULATION | | 4.55 |




● Full-Time Out Patient Clinic
■ Part-Time Out Patient Clinic
□ Day Treatment Programs
* Transitional Living Programs

In comparing the current service system for adults with severe disabling mental illness with the ideal described in the "vision", it is clear that further development is necessary in almost all areas. This Plan includes goals to improve the service system in a number of the areas identified in the above discussion of the current system. Among those areas are case management (Goal B.12), vocational services (Goal B.16), crisis intervention (Goal B.10), pre-admission screening (Goal B.2), and psychiatric services (Goal C.7).

# VI. GOALS

The Department has adopted the following goals for the FY 1992-1994 Revision of the State Mental Health Plan. Some reflect a continuation of activity from the FY 91-93 plan. Others are new. All were selected for action from among other important issues/problems that deserve attention. The availability of staff and financial resources were constraining factors in the selection process.

Some of the goals which have been established will require substantial expenditure of funds. Whenever possible the Department will seek expanded funding in order to provide expanded services. When additional funding is not available, the Department will evaluate the importance of the activity or service proposed by the planning objective in comparison with the importance of other activities or services currently being funded.

The goal statements are arranged in three categories: 1) Child and Adolescent Services; 2) Adult Services; and 3) System Development Activity which is integral to Child and Adolescent Services and to Adult Services. Child and adolescent and adult services are identified as separate components and can be viewed as essentially separate plans. The system development goals are essential elements of each of the plans. In other words:

| | | |
|---|---|---|
| C/A Service Plan | = | C/A Goals + System Development Goals |
| Adult Services Plan | = | Adult Service Goals + System Development Goals |

The Department believes that these goals are reasonable steps to take toward the ideal service systems which are described in Sections IV and V of this Plan. An idealized service system will not be realized by FY 1994 but the accomplishment of these goals will move the system in the right direction.

## VI.1 Part A: Child and Adolescent Services

A.1 Goal Statement: Develop and establish a comprehensive, written interagency agreement among the Departments of Family Services, Social and Rehabilitation Services, Health, Corrections and Human Services, and the Office of Public Instruction establishing a joint process for planning and implementing services to children and adolescents with severe emotional disturbance and their families.

Narrative: The agreement will establish an interagency committee to meet on a regular basis to carry out the terms of the agreement, identify which children and adolescents will be the responsibility of each agency, specify methods of refinancing children services, promote culturally-sensitive community-based system of services, establish training and technical assistance, establish targeted case management, implement the State Mental Health Plan, establish common definitions, specify joint implementation of service projects under the second year of the CASSP project, and establish an automated information system.

The written agreement will be developed by an interagency team. Its first objective will be to complete an agreement between Family Services and Corrections and Human Services by December 1, 1991. This will be expanded to include the other agencies by July 1992. The proposed agreement will be submitted to the respective agency directors for approval. The base agreement will be developed initially with subsequent appendices detailing terms as they are completed.

A.2 Goal Statement: Establish a jointly-funded pilot program to demonstrate a comprehensive system of care for children and adolescents with severe emotional disturbance comprised of the full array of services defined in the Mental Health Division's vision statement.

Narrative: The system of services will be developed in phases and jointly with the Departments of Family Services (DFS), Social and Rehabilitation Services, the Office of Public Instruction, and a local community. The system's development will be incremental. The first step will be establishment of a community organizer position

through funding from the CASSP project. A contract will be written by November 1, 1991 and a person hired by January 1, 1992.

The second step will be the implementation of targeted case management for children and adolescents in Missoula County funded by Title XIX (medicaid) by December 1991. This includes the hiring of a case manager through CASSP project funds to provide targeted case management services to SED youth who are not Title XIX eligible in Missoula County. This will be a joint project with the Department of Family Services, Missoula County Commissioners, and the Western Montana Community Mental Health Center.

The third step involves the Mental Health Division and the Department of Family Services in jointly implementing demonstration projects proposed and funded by DFS for fiscal years 1992-93. A part of this joint effort will be the development of a state plan for children's services under the leadership of the Department of Family Services in accordance with SB 205. Participants will include the CMHC's and regional planning councils of DFS.

The fourth step will be to obtain additional funding for service development through grants from federal governments and private foundations. A grant writer will be available by contract under the second year of the CASSP project. This will be accomplished by September, 1992.

The fifth step is to develop and expand an informed constituency and involve it in the formulation and passage of essential legislation and funding. This is to be accomplished by sharing information with various boards, committees, organizations, and parent support groups and by contracting with a parent advocacy organization for training of parents as advocates. This is to be accomplished by September, 1992.

The sixth step is to develop services that will enable adolescents with severe emotional disturbance and their families to experience a passage from the children's service system to the adult system without a break in essential services. The services will be directed at enabling an adolescent upon reaching age of majority to live in an environment that is as independent as possible. The first service needed

is case management. The identification of the types of services needed will begin at the Third Annual State Conference On Mental Health Issues with a panel presentation on transition services. This will be accomplished in October, 1991. Services demonstrated as appropriate and effective will become a part of the contracts between the Mental Health Division and the regional CMHCs beginning with FY 98.

A.3 Goal Statement: Develop and implement a proposal to reorganize the financing of services for children and adolescents with severe emotional disturbance.

Narrative: This goal is essential in developing an array of services. It involves the completion of an interagency study by December 31, 1991 to find ways to increase non-state funds. The results of this study would be used by the Departments of Family Services (DFS), Social and Rehabilitation Services (SRS), Health, and Corrections and Human Services (DCHS) in the development of their respective budgets for fiscal years 1994-95. The ultimate goal would be funding for the implementation of a statewide system of services by the year 2000.

To implement this goal the Mental Health Division would contract with a consultant to assist an interagency team comprised of DFS, SRS, and DCHS by October 1991. The study would be completed by December 31, 1991, and its results and recommendations would be included in the agencies' budget proposals for FY 94-95.

VI.2 Part B: Adult Services

B.1 Goal Statement: Establish a clearly articulated mission for Montana State Hospital, Warm Springs Campus; develop programs which are consistent with that mission and with Joint Commission on Accreditation of Health Care Organizations (JCAHO) accreditation (FY 92).

Narrative: A Program Development Committee, composed of seventeen professional staff members at the Montana State Hospital (MSH), was appointed in January, 1991. Among the most important tasks delegated to the committee were the formulation of a recommended mission statement for the state hospital and a request that the committee make recommendations for changes in the hospital's organizational structure that will improve treatment and rehabilitation services while ensuring congruence with state statutes, the mission statement and JCAHO standards. The Program Development Committee submitted a proposed mission statement to the hospital administration in July, 1991. At the same time, the committee also submitted two separate proposals for modifications to the hospital's organizational structure and treatment delivery system.

Information on the hospital's present treatment unit structure has also been gathered. A report was completed on August 5, 1991 that describes the programs and patients on each unit of the hospital. Using this and other information, the hospital administration will respond to the proposals submitted by the Program Development Committee before October 31, 1991. This response will provide a framework for making changes to the hospital's organization and treatment program structure. From this point specific descriptions of, and objectives for, each separate treatment unit and program will be prepared by February 15, 1992. A timetable for implementing changes in the hospital's organizational structure and treatment programs will be developed once the extent of these changes is determined.

B.2 Goal Statement: Appropriately screen 100% of voluntary admissions to Montana State Hospital, Warm Springs Campus.

Narrative: Current state law requires that for all voluntary admissions to MSH a community mental health center must verify that facilities are not available in the mental health region to provide adequate evaluation and treatment. The Department will develop a system and adopt administrative rules establishing procedures to assure that screening takes place as required.

The rule will be submitted to the Secretary of State by March, 1992. Procedures and designated admission-screening mental health professionals will be identified and operational by July 1, 1992.

B.3 Goal Statement: Expand discharge planning at MSH to ensure that comprehensive planning which includes community mental health center (CMHC) involvement occurs for all MSH - Warm Springs Campus patients (FY 92).

Narrative: The process of patient discharge planning at the hospital will be reviewed and updated. Formal discharge planning for each patient will begin at the time of admission to the hospital and will involve staff members from the hospital and the community mental health center that serves the patient's home community. This will help to identify the components of hospital treatment that will be important in helping patients prepare for a successful return to their home community. It will also help to identify the services and supports that patients will need upon discharge from the hospital. The implementation of these changes will mean that purposeful aftercare planning begins at an earlier time in the patient's hospitalization than it does currently and that links between hospital staff members and community mental health service providers in making discharge arrangement are formalized.

To facilitate this process several hospital staff members will be identified as "aftercare coordinators" and will have responsibilities for developing and regularly updating the aftercare plan of each patient assigned to them. This will be done in conjunction with designated staff members from each region's community mental health center. These individuals will be designated by January 1, 1992. Additionally, a draft format of a general comprehensive discharge plan will be

developed so that it can be reviewed by the aftercare coordinators and appropriate community mental health center staff members by February 1, 1992. The draft plan will be accompanied by a procedure for completion of the plan. A final format for the discharge plan and a procedure for its completion will be adopted by March 1, 1992. The plan and accompanying procedure will be put into use immediately upon adoption.

B.4 Goal Statement: Identify/develop programs for mentally retarded sexual offenders and discontinue services to that group at Montana State Hospital, Warm Springs.

Narrative: The Department does not believe it is appropriate for the state hospital to be the site of treatment programs for sexual offenders who have limited intelligence. Yet, in part for public safety reasons, several (approximately 10 to 12) such individuals have been committed to the state hospital although specialized treatment for the problem behavior is not provided. The first step in reaching this goal is to identify specific services that would be most appropriate for these individuals and then work toward establishing those programs, to the extent possible as community-based alternatives. This goal is part of the effort to clarify and clearly articulate the role of the state hospital within the service system and also to provide an appropriate type of service and setting for individuals who are currently being inappropriately sent to the state hospital. Identification of service needs and resources will be completed in FY 92 with strategies for program development to follow in FY 93.

B.5 Goal Statement: Identify/develop outpatient programs for people with personality disorders and reduce the voluntary and civil involuntary utilization of Montana State Hospital, Warm Springs by this group.

Narrative: An increasing proportion of admissions to the state hospital are people who have personality disorders. Probably some of these people can be appropriately served at the state hospital for short periods of time. However, many of these people can receive needed treatment in less restrictive and more appropriate

settings. The Department will identify the kinds of programs needed and will contract for those services. This is another step to clarify the role of the state hospital within the mental health system and to allow it to devote its resources to serving those who need that level of care. Identification of services needed and available resources will be completed in FY 92. Contracts for the provision of needed services will begin in FY 93.

B.6 Goal Statement: Amend statutes on criminal court admission to the mental health system to assure that people ordered to Montana State Hospital by the criminal courts have a mental illness which requires the level of care provided at the hospital.

Narrative: Some people who are served at the state hospital have been found to be not guilty by reason of mental disease or defect or have been sentenced to the state hospital after having been convicted of a crime. In some cases these people are clearly mentally ill and in need of inpatient psychiatric services. Other people, however, do not need to be in an inpatient mental health treatment program, and yet, due to the criminal court order and/or the reluctance of the criminal justice system to see the person released from custody, they spend many years at the state hospital. It is highly inappropriate for some of these people to be confined to a state mental institution, and it is highly inappropriate for the staff of the state hospital to be providing services to these individuals rather than to people who are truly seriously mentally ill. The Department will draft legislation which, while continuing to allow the placement of people in the state hospital through the criminal court system, will clearly indicate that only those people who need that level of care will be placed in the institution and that those people who are placed in a state hospital will be discharged to other settings when their condition allows. The proposed legislation will be submitted to the 1993 Legislature.

B.7 Goal Statement: Establish a more clearly articulated mission statement for the Center for the Aged.

Narrative: The intent of this goal is to clarify the role of the Center within the Montana mental health system. This will allow Center staff to more clearly structure the services of the Center as part of a continuum of services that are provided in the state. This mission statement can also be used to guide community providers in utilizing the Center appropriately. Developing a mission for the Center will include developing new programs and insuring that old ones meet the standards that are set by the JCAHO accrediting body. This would be helpful should the Department ever consider obtaining this type of accreditation for the Center.

The Long Term Care Relocation Committee began a revision of the mission statement at the Center last year. It was felt at that time that the public, and even service providers, did not have a clear understanding of the type of resident that could be appropriately served at the Center and how the facility is different from other institutions. The mission statement that was developed at that time will be used as a springboard for further developing the mission for the Center after review by the Center's management team. The Mental Health Division will then decide what changes, if any, to make in the mission and direction of the Center and will then modify the mission statement accordingly. JCAHO accreditation standards will be reviewed by the Center staff to compare current and pending programs to the standards. These would then be incorporated into the mission statement where feasible.

TIME FRAMES: September 30, 1991 - Center staff will compare programs with JCAHO standards; December, 1991 - Center staff will review programs and mission statement and send revised copy to Division for comment and modification; January 15, 1992 - Division staff will make modifications and changes to the mission statement and begin program implementation.

B.8 Goal Statement: Strengthen the admission screening process at the Center for the Aged and establish a discharge planning process that includes aftercare planning for all residents.

Narrative: The goal of strengthening the admission process at the Center will insure that only those residents who cannot be served in the community and do not require

the services of MSH are admitted to the Center. In the past the Center has been viewed as a facility where elderly persons who are chronically mentally ill and in need of supervision could spend the rest of their lives. A more structured discharge planning process would encourage other placements in the community from the time of admission. The expectation would then be that residents could be at the Center for a period of stabilization, not as intense as acute or active treatment, and that they would eventually be returned to the community when appropriate services are developed and made available.

The administrative rules that cover admission to the Center will have to be reviewed as well as the admission application to the Center. There are many ways to strengthen the admission screening process, including requiring certification from community nursing homes that a person is not appropriate for their facility.

TIME FRAMES: November 30, 1991 - Center staff will review administrative rules, application forms and policies regarding admissions and discharges and make recommendations for changes; January 30, 1992 - Division staff will review changes in policy or admission application forms and make suggestions for changes in Administrative Rules.

B.9 Goal Statement: Identify program components needed to serve in the community all current "personal care" residents at the Center for the Aged, and develop or ensure the provision of community services to allow the Center to discontinue service to this population.

Narrative: Although all of the beds at the Center are licensed as Intermediate Care by the Department of Health, there are many current residents who do not require that level of physical care. The goal is to identify those program components that exist at the Center that would have to be duplicated in the community in order to successfully place these individuals in a non-institutional facility.

The Division will review the services that are provided at the Center for these individuals and determine which resources are available in the community, either through the mental health system or through aging services. It will encourage SRS

to implement a pilot project providing reimbursement for personal care for some of these individuals. There will undoubtedly be many service providers willing to provide services once personal care is a reimbursed service under Medicaid. It is unlikely that this will happen in the next four years on any large scale due to the cost. If new funds are not available, residents' personal funds and re-directed state funds will be considered as funding sources.

TIME FRAMES: October 15, 1991 - Invite the Aging Coordinators of all of the CMHC regions to tour the Center and to inform the staff of available resources in their areas; January 15, 1992 - Review the services available to these residents at the Center; January 30, 1992 - List those resources available to this population in community settings; March 15, 1992 - Work with SRS to implement a pilot project to reimburse for personal care to a small number of mentally ill residents; March 15, 1992 - Decide how to handle residents who are at a personal care level and do not wish to be discharged from the Center; January to June, 1992 - Continue to work with personal care-level residents on possible community placements; work on establishing more supportive relationships with the community mental health centers on discharges of elderly persons from the Center.

B.10 Goal Statement: Eliminate the detention of mentally ill persons in jail pending a civil commitment hearing; divert from jail persons accused of minor misdemeanor offenses who appear to be seriously mentally ill; and provide alternatives to the placement of mentally ill persons in jail, as of July 1, 1993.

Narrative: HB 103, a bill passed by the 1991 legislature, requires that the Department assist all of the counties in the state in developing plans for the implementation of appropriate alternatives to the jailing of people with mental illness. The development of crisis intervention services and/or other appropriate services in each county is required to be accomplished by July 1, 1993.

The Department will be assisting the counties in this task through the provision of technical assistance and information regarding needed services. Also, the Department will be establishing crisis intervention programs within the limitations of the current budget.

The first step in assisting counties to eliminate the use of jails was accomplished on September 9, 1991 when a planning meeting was conducted by the Department focusing on the requirements of HB 103, methods of developing county plans and other aspects of implementing this law. Invitations to this meeting were extended to a wide variety of representatives from government, professional and mental health associations/organizations.

The specific manner in which the Department will assist the counties will, in large part, be defined at this and subsequent planning meetings.

B.11 Goal Statement: Develop at least one consumer-run drop-in center.

Narrative: An important component of the mental health system is a place where people with serious mental illnesses can gather for socialization, recreation and mutual support. Traditionally this has been one of the functions of day treatment programs in Montana. There is a growing movement among consumers to have a more direct role in providing this type of service for themselves separate from treatment programs. Through the community support project, one consumer drop-in center will be developed during Fiscal Year 1992. Based upon an analysis of the success of this program, additional consumer-run programs will be developed. Options for funding of these programs will be explored.

B.12 Goal Statement: The State will complete the development of a system to provide case management services to all eligible adults who will accept this service.

Narrative: The target group has been defined and a case management system is being implemented which should be able to provide case management to eligible adults across the state. This will involve the use of "clinician case managers" who provide case management to individuals to whom they provide other mental health services and "dedicated case managers" who provide only case management services.

Funding will be provided via a combination of state funds, some of which will be redirected from other services, and federal funds including Medicaid and the homeless block grant. By June, 1992, case management services will be available to all targeted adults who choose to accept the services.

B.13 Goal Statement: Identify and develop services and/or system changes that will improve the quality, relevancy and/or utilization of home- and community-based services and supports available to elderly individuals who have a severe and disabling mental illness.

Narrative: CMHC elderly service coordinators will be asked to identify ways to more effectively serve the elderly within the array of mental health services and supports available. Model programs and authorities in the field will also be contacted. By June, 1992, we will identify changes we expect to make and develop strategies for implementing program changes.

B.14 Goal Statement: Develop a full continuum of vocational services within each day treatment program and expand supported employment options.

Narrative: This goal has program expansion and regulatory elements. A number of day treatment programs for adults with mental illness include a variety of vocational services varying from pre-employment "work units" to assistance in acquiring and keeping competitive employment.

The Department will work toward developing a full continuum of vocational options in all day treatment programs during FY 93. Expanded supported employment capacity will be pursued during FY 93 and FY 94 with particular emphasis placed on providing supported employment which is consistent with the skills and interests of the consumer and also provides the option of less than half-time employment.

## VI.3 Part C: System Develoment Activities

C.1 Goal Statement: Increase the Division's annual fiscal support of each CMHC region to at least the highest per capita rate presently paid to any CMHC region ($9.55 per capita) while achieving an annual rate of state hospital utilization by each CMHC region at least as low as the lowest per capita rate presently attained by any CMHC region (2.58 voluntary and involuntary annual admissions per 10,000 population).

Narrative: The Division presently supports community-based services in one CMHC region at a significantly higher per capita level than that enjoyed by the other CMHC regions. That region has also exhibited the lowest rate of admissions to the state hospital. During FY 92 the Division will work with consumers, advocates, providers and others to develop a method to equitably distribute any increase in funding among the CMHC regions conditioned upon a region's planned efforts to reduce the rate of admissions to the state hospital from the geographic area they serve through development of appropriate, effective alternative services.

C.2 Goal Statement: Develop the rehabilitation services option under Medicaid with an emphasis on crisis intervention and non-center-based rehabilitation services.

Narrative: The rehabilitation option will provide substantially more flexibility in delivering appropriate services and allow us to develop more responsive crisis and support services and encourage better utilization of available community resources. Medicaid personnel and mental health agencies in other states will be used as resources in identifying tasks and strategies. A State Medicaid Plan amendment will be submitted to the Health Care Financing Administration by May, 1993. Final approval is targeted for September, 1993.

C.3 Goal Statement: Complete development and implementation of an integrated mental health data system.

Narrative: An integrated mental health data system which will contain all client and service data from the institutions and community programs and reside in a single location, in the Department's computer, will be developed.

Existing data systems at Montana State Hospital (MSH), the Center for the Aged (CA), and the CMHCs must be expanded and modified to include all data recommended by the Mental Health Statistics Improvement Program (MHSIP), as well as additional data needed for management purposes at the local, institutional, and Department level. Definitions of data elements must be standardized across the system, and the Department's computer capabilities must be modified to accommodate needed changes and to allow CMHC data to reside in the Department's mini-computer.

A key element of the revised data system will be the addition of a unique client identifier which will allow access to client and service data across all service providers in the public mental health system. Another important element will be the capture of event data from the institutions. Funding has been granted by the National Institute of Mental Health (NIMH) to support our efforts to develop a data system that incorporates the recommendations of MHSIP for data elements and system integration capabilities.

The process of developing and implementing the new system will involve three separate components: a) CMHC system enhancement and standardization, b) modification of MSH and CA data collection, and c) development of computer capabilities at the Department level to accommodate changes and integrate data. Tasks and time lines for each component will be identified separately. Admission data modifications at MSH and CA will be implemented in FY 92, event reporting in FY 93. One or more pilot programs will be undertaken in the CMHCs in FY 92, with all centers enhancing their systems in FY 93.

C.4 Goal Statement: Accomplish a comprehensive review and revision of the mental health system program evaluation process to include consumer involvement, the development of outcome measures, a self-evaluation process, consistency

and coordination with licensing standards, new residential service standards and standards for child/adolescent day treatment.

Narrative: This will be a major effort to upgrade and refine the procedures and processes which the Department utilizes to ensure compliance with contract requirements and CMHC standards. Furthermore, we plan to upgrade the standards themselves to more accurately reflect currently- accepted levels of practice and service provision. The result of this effort will be the refinement and enhancement of the services which we purchase and the manner in which we monitor the provision of these services.

This effort will begin immediately with a series of meetings with the Board of Visitors to review the evaluation procedures used during the past two years. Attention will be given to discarding inefficient methods and incorporating new ideas aimed at streamlining the evaluation process

We have already made a preliminary start on revising adolescent day treatment standards, and we plan to complete this project prior to the end of the fiscal year. This entire project is scheduled for completion by FY 94.

C.5 Goal Statement: Establish procedures to determine the capacity of individuals to give informed consent and procedures to seek consent to treatment for people who cannot give informed consent.

Narrative: The Department is now required under law to develop a process whereby an individual's ability to give informed consent can be determined. The first part of this process will involve defining informed consent (i.e., identifying the basic elements). Procedures for measuring an individual's ability to give informed consent will, of course, need to be developed as well.

In addition to developing assessment procedures, the Department will also be working to identify approaches to situations involving clients that are unable to provide informed consent. We will seek considerable input from consumers and advocates, as well as from psychiatric and legal resources, during the course of this project. Projected completion date for this task is July 1, 1992.

C.6 Goal Statement: Develop and promote training to improve the cultural sensitivity of mental health system workers, especially for Native American cultures.

Narrative: A cultural liaison will be developed in each mental health center with the necessary skills and knowledge to provide mental health services in a culturally-sensitive manner to minority groups, particularly Native Americans. The cultural liaison will be a designated professional staff person who will be freed from duties to attend training identified by the Department as essential to developing the skills and knowledge to carry out this role. The cultural liaison will have as an additional professional duty the responsibility for consulting with other service providers within the CMHC on delivery of culturally-appropriate services.

The Department will include as part of the contract with CMHC's the requirement to designate a cultural liaison by July 1, 1992. The Department, in collaboration with PLUK and other state agencies, will arrange for the completion of a minimum of one training session by August 31, 1992 for the cultural liaisons. The Mental Health Division will complete a training plan which provides for a minimum of one training session per year on Native American cultures which the liaisons will be required to attend.

The training of the cultural liaisons and other mental health professionals is an ongoing goal. The Department will include in each of its contracts for provision of mental health services to adults or children the requirement that the contractor demonstrate how cultural sensitivity is being provided in the delivery of service, and how training regarding cultural issues of clients served is provided to all staff.

C.7 Goal Statement: Develop the availability of telephonic psychiatric consultation on medication management for primary care physicians serving patients with mental illness.

Narrative: The reality of mental health services in a rural state is that many people with mental illness do not have a psychiatrist available to them. The Region I CMHC catchment area, for example, is an area of 47,747 square miles which does not have a single psychiatrist living within it.

Psychiatrists will be identified who will be available to consult by telephone with primary care physicians on medication issues. It is anticipated that this consultative service will be available by FY 93.

C.8 Goal Statement: Establish an annual Consumer Support Program (CSP) "Learning Community Conference" and participate with other agencies in annual conferences on severely emotionally disturbed children and adolescents.

Narrative: The two types of conference identified in this goal statement have been provided annually for the preceding two years. The Department's participation has been through federal grant funding. These conferences provide valuable training for those in the mental health system serving priority groups, and they serve as a focal point for the exchange of information and the development of a sense of community for the people who work in the service system. The Department intends to continue participation in these conferences for the remainder of the federal grant availability and beyond to emphasize the importance of services to adults with serious mental illness and children and adolescents with severe emotional disturbances.

C.9 Goal Statement: Establish a cooperative process among the mental health agencies to identify particular areas of success and expertise in operations and programs within the service system. Encourage and promote a mechanism through which such expertise can be shared among all providers.

Narrative: Among the state's five community mental health centers and two inpatient programs there are notable differences in accomplishments in both programmatic and operational areas. For instance, one region enjoys a significantly lower per capita utilization of the state hospital than do all others. Some agencies are remarkably successful in recruiting professional staff despite geographic constraints. Some programs are developing proficiency in specialized services such as therapeutic foster care, crisis intervention, and forensic assessment. By promoting the identification and sharing of successful knowledge, techniques, and philosophies it should be possible to improve services in each agency and, consequently,

throughout the state to seriously emotionally disturbed children and to adults with a serious and disabling mental illness.

C.10 Goal Statement: Provide, in cooperation with the Mental Health Association of Montana, an annual training conference for mental health service providers designed to meet identified training needs.

Narrative: If mental health professionals are to provide effective treatment, they must be knowledgeable about recent developments and aware of current practices. The Division will work with the Mental Health Association and other groups and individuals to recognize areas of particular need or significance, identify individuals or programs with particular expertise, establish accessible locations and convenient times, encourage participation by the greatest possible number of public-sector service providers, and provide financial and administrative support for an annual conference.

This goal will be accomplished with a training conference held in FY 92 and each year thereafter.

C.11 Goal Statement: Develop, promote, and provide an orientation program for county attorneys and district judges to ensure they understand and recognize the appropriate roles of the Montana State Hospital and the community-based mental health system.

Narrative: One significant obstacle to limiting the population of the Montana State Hospital to those with a severe and disabling mental illness who can not be adequately served in the community is that courts repeatedly order the commitment of individuals for whom the hospital is not an appropriate setting. Under the assumption that this occurs because the officers of the court do not understand the role and limitations of the hospital, a program to instruct county attorneys and district judges in the state's commitment law, the mission and role of the state hospital, and the alternatives to hospitalization that are available is a reasonable first approach to solving this problem. The Department will work with the Attorney

General, the County Attorneys' Association, the Corrections Division and other appropriate agencies to produce and present materials in an appropriate forum that recognizes the existing knowledge base and experience of the participants. The Department will strive to make use of both consumers and mental health professionals in this effort which will emphasize the resources available in the local community and the economies that can be realized by using them.

Elements of an appropriate training program, including an implementation schedule, will be identified in FY 92. Implementations will occur in FY 93 and FY 94.

C.12 Goal Statement: Establish a system of internship and practicum opportunities in the public mental health system with the requisite changes in procedures and policies to encourage students to perform their required field experiences working with people with serious mental illness or with children and adolescents who have emotional disturbances.

Narrative: A student who has experience with a particular organization or setting is much more likely to choose it as a work setting. This goal is designed to increase the number of students choosing to work in the public mental health system. The Division will research, coordinate and promote such changes as are necessary to create supervised internship and practicum opportunities in the CMHCs, the Montana State Hospital, and the Center for the Aged, and will lead the development of linkages between the mental health service system and the institutions of higher education to ensure that faculty and students understand and utilize those opportunities. Additionally, the Division will develop, suggest, and promote necessary incentives and supports that will increase the number of students performing their required field experience in the public system.

Accomplishment of this goal will require cooperation between the Division, the mental health centers, the institutions of higher education, and individual mental health professionals. It may well require legislative action to establish sufficient financial support for student interns and for those agencies taking on supervisory roles. Activity aimed at accomplishing this goal will begin in FY 92 and results in the form of significantly more students performing internships in the State Hospital, the Center for the Aged, and all the CMHCs will begin to occur in FY 93.

C.13 Goal Statement: Develop a model curriculum for the training of Master's-level mental health generalists who will serve the seriously mentally ill; have the curriculum adopted by at least one program within the state's institutions of higher education.

Narrative: Because few programs in Montana's institutions of higher education prepare students to treat serious mental illness there is a scarcity of appropriately-trained staff in the public system. We want to ensure that there are opportunities for Montana students to receive an education that will allow them to effectively work with those with severe and disabling mental illness. Through the Human Resource Development (HRD) Project, the Division will facilitate and guide the development of a model curriculum which will specify and define the minimum essential elements for training generalist mental health practitioners with a solid grounding in the recognition and treatment of major mental illness. Graduates would work within the public mental health system, performing such functions as assessment and evaluation; outpatient group, individual, and family therapy; crisis intervention; case management; and treatment planning.

The components of this curriculum will be determined by a curriculum review team comprised of educators, providers and consumers. They will consider components identified through a survey of the Montana mental health community, evaluate existing curricula and integrate recommendations from an outside consultant. Integration of significant elements of the model curricula into existing training programs will require substantial collaborative efforts from the curriculum review team, Division administration, CMHC leadership and educators, and may depend on incentives developed by the mental health service system. The curriculum definition process should be complete by the end of FY 92. Adoption of the curriculum by at least one training program could begin in FY 93 and may take several years to complete.

C.14 Goal Statement: Develop a model curriculum for the training of case management and psychosocial rehabilitation workers who will serve the seriously mentally ill; have the curriculum adopted by at least one

undergraduate program or department within the state's institutions of higher education.

Narrative: Again through the HRD Project the Division will facilitate and guide the development of a model curriculum which will specify and define the minimum essential elements for training people to competently perform entry-level tasks within the public mental health system. Graduates of a program integrating the model curriculum would have a sufficient base of knowledge about serious mental illness and community-based treatment and rehabilitation approaches to be effective case managers or to work in a psychosocial rehabilitation program, a group home, or an adolescent day-treatment program.

The process for accomplishing this goal and the times for doing so are identical to those specified above for developing the model Master's-level curriculum.

C.15 Goal Statement: Develop a system which will identify, promote and support persons who are place-bound in rural communities, mental health consumers, and/or under-educated mental health workers to allow them to acquire training under one of the model curricula or another appropriate program within Montana and return to the home community to provide mental health services within the public system.

Narrative: Ensuring that appropriate educational opportunities are available is not sufficient. To achieve an adequate supply of competent staff to serve the seriously mentally ill and seriously emotionally disturbed children, it is necessary to foster the education of people representing selected groups. Following development and implementation of the model curricula, the HRD Project will perform research, negotiate supports, promote policy changes, and perform other necessary functions which will allow and encourage people from the categories listed to attain an education through the program(s) utilizing the model curricula and will ensure that they return to the public mental health system for employment, ideally in the rural community or area from which they originated.

Accomplishing this goal will require a variety of activities, some of which can not be foreseen. It will probably be necessary to promote and negotiate financial support

for the student from the educational institution and/or the mental health agency (with concomitant service obligations, perhaps), and to ensure that necessary and reasonable accommodations and supports (social and academic) are available at the institution. Additionally, the Division may attempt to locate or provide financial support for appropriate students or may establish incentives for CMHCs or educational programs to participate in this program. Activities directed toward this goal will begin in FY 93 and the first student(s) will begin studies in FY 94.

C.16 Goal Statement: Develop a program to promote and encourage various forms of staff exchanges between Montana institutions of higher education and the state's public mental health system.

Narrative: Collaboration between higher education and mental health service providers is an effective means of influencing educational programs to focus on the needs of the service system. Staff exchanges can also serve to keep providers current and to reacquaint academicians with the problems of serious mental illness. The Division will research, coordinate and promote such changes as are necessary to create exchange opportunities between the system of higher education and the CMHCs, the Montana State Hospital and the Center for the Aged, and will lead the development of linkages between the mental health service system and the institutions of higher education to ensure that faculty and providers understand and utilize those opportunities. Additionally, the Division will develop, suggest, and promote necessary incentives and supports that will increase the number of faculty and service system staff exchanges.

Accomplishment of this goal will require cooperation between the Division, the mental health centers, the institutions of higher education, and individual mental health professionals. It will require financial support for faculty and providers from those institutions and agencies participating. Activity aimed at accomplishing this goal will begin in FY 92 and results in the form of active exchanges will begin to occur in FY 93.